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ABSTRACT

The health problems of today are different from those of the past and therefore demand new health care approaches and policies. The goals of the conference on disease prevention and health promotion were: to increase knowledge and understanding of the range of approaches to health promotion; to exchange information about the cost and effectiveness of these approaches; and to influence health policy. The conference proceedings contain abstracts of presentations and available information on cost effectiveness. The conference reflected three positions. One position, held by traditional medical practitioners, suggests that the concepts of holistic health are nothing more than magic and mysticism. Another position reflects the concern that traditional medicine has no concern for the whole person and that only holistic health has answers for treatment and prevention of illness in the future. A third position is the claim by some practitioners that these new concepts of health were already part of good clinical practice. (JN)

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The Shifting Medical Paradigm: From Disease Prevention To Health Promotion

PROCEEDINGS

Conference Sponsored By:

CENTRE FOR CONTINUING EDUCATION
UNIVERSITY OF BRITISH COLUMBIA,
HEALTH AND WELFARE, CANADA
BRITISH COLUMBIA MINISTRY OF
HEALTH, VANCOUVER HEALTH
DEPARTMENT

IN COOPERATION WITH:

EAST-WEST ACADEMY OF THE HEALING
ARTS, SAN FRANCISCO
CONTINUING EDUCATION IN HEALTH
SCIENCES, UNIVERSITY OF BRITISH
COLUMBIA
PREVENTIVE MEDICAL CENTER,
NORTHSHORE, NORTH VANCOUVER

HELD AT:

ROBSON SQUARE MEDIA CENTER
VANCOUVER, BRITISH COLUMBIA
MARCH 20TH AND 21ST, 1980

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CONFERENCE THEME

The health problems of today are very different to those of the past and demand new health care approaches and policies.

The purpose of the conference is:

- to increase knowledge and understanding of the range of approaches to health promotion;
- to exchange information about the cost and effectiveness of these approaches;
- to influence health policy.

PLANNING COMMITTEE

Clair Buckley, Executive Director of Planning and Development, British Columbia Ministry of Health
Maurice L. Chazottes, Executive Director Health Promotion, British Columbia Ministry of Health
Anne Ironside, Program Director, Lifestyles, Centre for Continuing Education, The University of British Columbia (Chair, Conference Planning Committee)
Dr. John Milsum, Professor, Department of Health Care and Epidemiology, and Director, Division of Health Systems, Coordinator's Office, Health Sciences Centre, The University of British Columbia
Dr. Joe Neidhardt Director, Preventive Medical Center, North Shore, North Vancouver
Dr. Effie Poy Yew Chow, Director, East-West Academy of the Healing Arts, San Francisco
Margo Sanderson, Program Consultant, Health Promotion Directorate, Health and Welfare, Canada
Dr. Mal Weinstein, Health Planning, Vancouver Health Department

FOREWORD TO HEALTH PROMOTION CONFERENCE PROCEEDINGS

These proceedings cannot possibly capture the tremendous level of energy and cooperation that prevailed at the conference. This was the first national conference on health promotion, the "third paradigm", ever held in Canada. Its 350 participants ranged from "true believers" to "true skeptics". Topics ranged from holistic health to cost-effectiveness. Participants were drawn from the community and over a dozen different professions. Channels of communication which were once blocked or non-existent were opened. Physicians, nurses, nutritionists, and others now share a common experience which will serve as a foundation for future collaboration rather than competition.

This conference was modestly aimed at providing opportunities to share a certain understanding of emerging trends in health promotion with an eye to costs and benefits. The process has begun. The proceedings contain abstracts of presentations and available information on cost effectiveness.

Resource people were all asked to indicate something about the costs and effectiveness of their services or programs. It is clear from the data presented that we lack hard information on either costs or effectiveness as a foundation for resource allocation. No doubt this same criticism holds true for traditional practice as well.

A common agreement to pursue better data on costs and effectiveness arose out of the conference. This means that practices and procedures which offer some promise for improving health deserve an opportunity for careful, systematic, funded scrutiny under controlled conditions using research methods appropriate to them.

Research allows traditional practices to be re-examined using new evaluative instruments, and allows new, even radical ideas to be tested without being dismissed out of hand.

The conference owes its existence to the support and enthusiasm of a number of people. Dr. Effie Poy Yew Chow wished to see a conference in Canada similar to the conference on public policy held in Washington, D.C., in 1978. Early discussions of the conference took place with Dr. Chapin Key, our Provincial Deputy Minister of Health, B.C. Ministry of Health and the University of British Columbia's Centre for Continuing Education. Subsequent support for such a conference came through his office and the inclusion of cost-effectiveness owes its life to Dr. Gerald Bonham, Senior Assistant Deputy Minister, Community Health Programs. Margo Sanderson, Health Promotion Directorate, National Health and Welfare, provided a keen sense of direction to the planning committee and secured her agency's commitment to underwrite the costs of bringing together North America's most innovative thinkers and doers in the area of lifestyle change. Dr. Joe Neidhardt, a pioneer in medically provided preventive service contributed an important community perspective to the planning committee. Financial support from the Vancouver Health Department makes it possible to offer the proceedings free of charge to the conference participants.

The conference showed that three extreme positions are untenable. One extreme position, held by traditional medical practitioners, is that the concepts of holistic health are nothing more than magic and mysticism. Another extreme, equally indefensible, is that traditional medicine has no concern for the whole person and that only holistic health has answers for treatment and prevention of illness in the future. A third position was the claim by some practitioners that these so-called "new" concepts of health were already part of good clinical practice. None of these positions stand up to close scrutiny. The conference provided a forum, which hopefully will continue for rational discussion.

This conference is only a beginning. Future conferences will afford us opportunities to shift the paradigm further toward a health concept in which traditional and alternative forms of health care and enhancement will share a common understanding.

Anne Ironside
Mal Weinstein

NOTES ON COST-EFFECTIVENESS

Health care is no longer a moral issue alone - it is big business. Reconciling individual "rights" to health and care with society's rights to ensure its money well spent, has forced health care funders to pay more attention to the costs and benefits and relative effectiveness of health interventions, than ever before. If preventive medicine and holistic health notions are to ever gain acceptance, they must compete with existing services by systematically gathering data on their costs and on their short and long term impact.

The conference planning committee asked all special session leaders to provide whatever data they could on the costs and/or effectiveness of their techniques. As expected, there is little information available at this time. Nevertheless, this focus was deemed necessary to make people aware of the need to develop methods to gather such data in order to be taken seriously by funders in the future. Moreover, an emphasis on costs and benefits showed clearly that we lack data to justify many existing services!

These proceedings, then, contain only bits and pieces of the cost-effectiveness puzzle. It is our hope that by including these matters at the outset, provisions will be made to provide even better data in the future.

THURSDAY MORNING PLENARY

ABSTRACTS OF PRESENTATIONS

IN SICKNESS OR IN HEALTH? :

A Look At Health Problems In The 80's

Mal Weinstein, Ph.D.
Director of Health Planning
Vancouver Health Department

This brief introductory address previews current and anticipated health problems. I anticipate that people will continue to die, become sick, and even experience feelings of well-being and joy during the 1980's. More and more individuals will learn skills which will enable them to move into this latter category. But I note with amazement that despite the capriciousness of biology, the way we live, our environment, and the inadequacies of our health care system, the vast majority of people in urban society today neither die nor are hospitalized during any given year.

With the elimination of the infectious diseases as major causes of death, and their replacement by accidents, suicide, and by chronic diseases of the heart, lung, and liver, we are moving into a third paradigm of health care aimed at the promotion of optimal health and well-being. This third paradigm builds upon the first paradigm which focused on death prevention, and the second paradigm which focused on prevention of chronic disease and disability. Bacteriology provided a knowledge base for the first phase which was led by physicians and centered in hospitals and clinics. Health care administration has added to this knowledge for the second phase which has been led by the nursing profession and is centered in community care facilitites. The third phase sees traditonal disciplines being joined by specialists in the behavioural sciences, marketing, and business to shift the focus of health to the home and the workplace. We are witnessing a change in the traditional pyramid of health care with the hospital at the base, to a spectrum or circle of health care with the hospital and the individual each taking responsibility for health and well-being.

It now should be very clear that we can no longer afford to maintain our fragmented approach to health and health planning. We must consider the allocation of health resources from the perspective of society as a whole. By focusing on the benefits and costs of alternative methods for treating and preventing disease and promoting health, governments, institutions and individuals will be better equipped to make the difficult choices that lie ahead.

WHAT IS BEING DONE?

Dr. Peter Banks, M.D., Past-President
Canadian Medical Association, British
Medical Association, British Columbia
Medical Association, 1st Medical Commissioner, Province of British Columbia

It is only forty years ago that William Beveridge assured us that national health insurance would lead to reduced health costs by preventing disease in its early states. A Welfare State was created throughout the western world and whatever its benefits, the saving of money is certainly not one of them. It is now obvious that a national health insurance program increases medical costs rather than the predicted reverse.

Some reasons for increasings costs are out of our control:

- technological advance
- aging population
- chronic disease as the dominant pattern
- decline in family support
- union demands

Some reasons for increasing costs are correctable:

- the "technological imperative" (Somers)
    - a) false quality control
    - b) sub specialization
    - c) legal demand
    - d) over use of drugs

- unrealistic attitudes towards death

- unrealistic expectations:
  - a) Medical: people find it difficult to accept the afflictions of aging. This can lead to unnecessary testing, consultation and even surgery;
  - b) Preventive: attempts to change a lifestyle after it has been established are difficult. It needs to be done during the formative years of childhood. The best place to do it is in the public school system.
  - c) Blank cheque payment: over utilization by patients in some cases, over servicing by doctors.

There will continue to be conflict between the medical profession and government about costs. Doctors wish to spend more money on behalf of their patients and of course, themselves. Politicians are interested in holding costs down. Fiscal responsibility must be built into a medical plan at the onset. It is politically difficult to introduce it later.

1. CANADA

HEALTH COST CARE INDICATORS

Indicator	1971-72	1972-73	1973-74	1974-75	1975-76
GNP % Increase	10.5	13.0	17.9	17.2	13.1
Federal Budget % Increase	13.0	9.4	22.5	28.0	15.9
Health Exp. % Increase	12.3	9.3	12.5	16.9	16.7

Source GNP -- Statistics Canada
Health Cost -- Health and Welfare Canada

1A. CANADA
HEALTH CARE COST INDICATORS -- 5 MILLIONS

Indicator	1971-72	1972-73	1973-74	1974-75	1975-76	1976-77
GNP% Increase	10.5	13.0	17.9	17.2	13.1	14.1
Federal Budget % Increase	13	9.4	22.5	28.0	15.9	13.4
Health Expenditure % Increase	12.3	9.3	12.5	16.9	16.7	15.3

Source GNP -- Statistics Canada
Health Cost - Health and Welfare Canada

1. Estimates only.

2. TOTAL HEALTH CARE EXPENDITURE AS A PERCENTAGE OF GNP AND PERSONAL INCOME

	% of GNP	% of Personal Income
1960	5.62	7.30
1965	6.07	8.20
1970	7.10	9.14
1975	7.10	8.63
1980*	7.20	8.80

* CMA Estimate

Source -- Health and Welfare Canada

3. PROPORTION OF GNP % SPENT ON HEALTH CARE -- 1965-1976

	1965	1966	1974	1975	1976
Canada	6.0	6.0	6.6	7.1	7.1
United States	5.9	6.0	8.1	8.4	8.6
Sweden	5.5	6.0	8.4	8.7	-
Holland	-	-	6.7	8.6	8.5
France	4.9	5.1	5.9	8.1	8.2
West Germany	4.4	4.5	6.9	9.7	-
Great Britain	4.1	4.3	5.3	5.6	5.8
Switzer-land	3.8	4.2	6.2	6.7*	

Source -- W.A. Glaser, "The Doctor Under National Health Insurance: Foreign Lessons for the U.S.", June, 1977.

* Final confirmed figures not available

4. EXPENDITURE PER PERSON ON PERSONAL HEALTH CARE, CANADA, SELECTED YEARS.

Type of Care	1960	1970	1975
Hospitals	$46.62	$130.15	$243.49
Physicians	19.82	48.38	83.62
Dentists	6.12	12.42	26.06
Prescribed Drugs	7.40	17.29	25.24
TOTAL	79.96	208.24	378.41

Source -- Health and Welfare Canada

THE PSYCHOSOMATIC MEDICINE CLINIC

Eike Diebold, Psychologist
Psychosomatic Medicine Clinic
Oakland, California

Beginning in 1976, a group of practitioners formed The Psychosomatic Medicine Clinic in Berkeley, California. At the present this group consists of three psychiatrists, two physicians, one clinical psychologist, two physical therapists, one nurse and two counselors. Two administrative staff members coordinate the smooth running of our Clinic. In my opinion the success of our Clinic can to a large extent be attributed to the supportive and comprehensive interaction of our individual staff members.

A pivotal concept for the Clinic staff is that all states of illness and health are inherently psychosomatic, i.e., involving psychological, physiological, spiritual and environmental factors in their etiology.

The Psychosomatic Medicine Clinic offers patient services including:

- Complete General Physicals and Medication Evaluation
- Stress Management
  - a) diagnostic evaluation of stress
  - b) stress reduction training
- Clinical Biofeedback
- Autogenic Training
- Complete Breathing
- Nutritional Counseling
- Computer-based "Nutrition and Physical Activity" Profiles
- Computer-based "Health Hazard Appraisal"
- Psychotherapy as an Aid to Medical Care
- Relaxation Training as an Adjunct to Psychotheraphy
- Cancer Counseling

All services are provided under direct medical supervision as the primary therapy or as adjunctive treatment. The Clinic accepts referrals from physicians and other health practitioners; in addition, many patients we serve are self-referred. Although most work at the Clinic is oriented towards the correction of pathology, an equally important emphasis is on disease prevention and on helping individuals to improve the quality of their lives and to function at optimal levels of health.

Assessing the major category of presenting problems, the following appear on top of the list: migraine and tension headache, Raynaud syndrome, insomnia, hypertension, chronic pain, allergic and asthmatic reaction, colitis, peptic ulcer, gastrointestinal disorders, neuromuscular dysfunction, torticollis, bruxism, as well as a wide range of neurotic reactions, the most prominent of these being anxiety.

The average number of treatment sessions is about eight; the range can vary a great deal, however. We have experienced everything from one session up to eighteen, and sometimes even more, depending on the presenting problem. All seem to benefit in varying degrees, ranging from a complete change inlife-style, to a lessening of intensity, frequency and/or duration of the presenting problem to obtaining optimal health.

It is somewhat difficult to assess the relative cost effectiveness of our Clinic with that of traditional Western Medicine. More complete information regarding this issue can be provided upon completion of a study of the Clinic under an NIMH grant which is now underway. The cost effectiveness of the Clinic will be demonstrated during the presentation by comparing the result we achieved with one particular patient with the results this patient obtained through other forms of treatment prior to coming to us.

HOLISTIC HEALTH

Effie Poy Yew Chow, Ph.D., President
East West Academy of Healing Arts
San Francisco, California

In the analysis of holistic health, four highly significant concepts help it to be more than just comprehensive care or humanistic medicine. First, the body/mind/spirit is integrated; second, stress is an important part in the critical development of disease; third, trans-cultural or ethnic healing practices are considered potential adjuncts to our present system of practice, and; fourth, there is a phenomenological theory of energy systems which prevade trans-culturally.

In this short period, the energy phenomenon will be emphasized.

(Text continues on page 52)

LUNCHEON ADDRESS

MAURICE L. CHAZOTTES
EXECUTIVE DIRECTOR OF HEALTH PROMOTION
BRITISH COLUMBIA MINISTRY OF HEALTH

LUNCHEON ADDRESS:

Maurice L. Chazottes,
Executive Director of Health Promotion
British Columbia Ministry of Health

This conference is of special interest since the Ministry is not only co-sponsor and underwriting about a third of the conference costs ($10,000 from the Ministry, $11,000 Health and Welfare, and the balance from Vancouver Health Department and U.B.C.) but Ministry personnel (Clair Buckley, Director of Planning and Development, Maurice Chazottes, Executive Director, Health Promotion and Brian Schmidt, Executive Assistant to the Deputy Minister, Chapin Key) participated as members of the Planning Committee and so helped to shape the content and direction of the conference.

Moreover the theme of the conference "From Disease Prevention to Health Promotion" accurately reflects the direction in which the Ministry is moving, placing increased emphasis on health promotion, lifestyles and preventive programs.

There is a standard gag to the effect that when a government department doesn't know what else to do it re-organizes. Not so in this case. Over the past year the Ministry has undergone a considerable re-structuring and re-organization for precisely the purpose of giving increased priority and emphasis to health promotion. This is an indication of the Ministry's efforts to shift as much as is possible from the "sickness" business, which has been the traditional preoccupation of "health" ministries, to the "health business".

Apart from the humane reasons of reducing the pain and suffering of disease and disability, there are pressing economic reasons for taking this new direction. For years the claim has been made that disease prevention and health promotion is the best dollar value available to governments and the taxpayer. By this time anybody who is at all aware of current events, who reads a newspaper, or listens to radio or watches television, knows that the costs of providing medical care have escalated alarmingly in recent years. They have literally exploded. All health jurisdictions have experienced this phenomenon.

During the past five years the budget for the Ministry has more than doubled. The current budget, 1980-81, is expected to be in the neighborhood of $1.5 billion.

Ministry of Health expenditures have been the largest of any single Ministry, consuming by itself more than a quarter of the entire provincial budget.

As one example we cite the percentage increases in the costs to Medicare of some medical services that took place during the "70's".

G.P. visit services	162.2%
Specialists visit services	235.4%
Anesthesia	135.8%
Obstetrics	97.3%
Surgery	83.7%
X-Ray	117.4%
Pathology	380.1%
Psychotheraphy	95.2%
Total fee for service	159.3%

And of course as we are all aware there have been similar dramatic increases in the cost of a day in hospital. Most of the health budget goes for hospital programs and medical services. Hospital programs take up more than half by themselves.

Nevertheless, there are constant pressures to have these expenditures increased, and increased considerably, by the public's expectations, (long term care and denticare as examples) by health professionals, (salary demands by nurses and the dissatisfaction of doctors with Medicare as examples) by the demand for hospital expansion, and the demands for sophisticated, expensive technology, as well as the increased cost of supplies and services.

The costs of health care have reached the stage where very pointed questions are being asked by those responsible for the administration of the health care delivery system. Questions such as, does this program prevent anything? If not, does it cure anything?

The question is also being asked: "What are we getting for the money we spend?". If, as we are, spending twice as many public dollars as we did five years ago does that mean that we are caring for twice as many people, or that people are twice as healthy? The answer in both cases is NO.

What then are the alternatives? What can we do to contain runaway costs? Part of it is beyond our control--the inflation that has hit all industrial economies. But a partial solution lies in providing as much home care as we can, avoiding as much institutional care whenever possible.

But by far our best hope lies in the direction of prevention and one of the most effective means of prevention is in the direction of health promotion.

During the early part of this century much of the money committed to health care went into preventing diseases and the results were dramatic. In those days, the ten major killers were T.B., Typhoid, Infantile Cholera, Dysentry, Croup and Whooping Cough, Polio, Alcoholism, Cancer and Malnutrition. Six out of the ten were infectious or communicable diseases.

Let's compare then with now, using 1921 data, the year when comprehensive statistics became universal, and 1977. The statistics illustrate the causes of death and the rates of death per 100,000 of population.

RATES OF DEATH PER 100,000 OF POPULATION

Going Down	1921	1977
Tuberculosis	77.7	1.1
Pneumonia	67.0	14.8
Nephritis	31.0	2.3
Communicable Diseases	39.2	4.1

Going Up	1921	1977
Heart Disease	90.0	249.3
Cancer	73.9	162.5
Cerebrovascular	37.5	73.3
Alcoholism & Cirhosis of the Liver	4.4	21.3

Let's look at another area.

	1921	1977
Stillbirths (per 1000 live births)	30.5	8.9
Infant deaths	56.5	12.6
Maternal deaths	4.8	0.1

An improvement but still too high. It has been estimated that for every infant mortality two or three will survive but they will be so damaged as to require lifetime care. The cost of providing this care over the lifetime of a person so handicapped is estimated at between $300,000 to $500,000.

The experts state that two-thirds of infant mortality and morbidity is preventable and again the prevention is directly linked to the lifestyle of the mother during pregnancy.

We now have well-documented evidence of the contributions the lack of exercise and malnutrition make to high blood pressure and cardiovascular disease. Similarly we also have well documented evidence of the contribution the abuse of alcohol and smoking cigarettes make to health, disease and lung cancer.

And the damage done by these causes applies, not only to the adult, but can also have a disastrous effect on the children and even on an unborn baby.

Given all this it is obvious that it is no longer possible as it was in the past to rely on government to provide the cure. The responsibility for the prevention of a breakdown in health now rests very much with individuals.

Governments cannot legislate lifestyles. It has been proven that prohibitive measures don't work. In our society any effort on the part of "big government" to interfere with an individual's lifestyle is strongly resisted. People insist on exercising the right to live as they choose.

At the same time, given the enormous cost to the public of providing health care and the rate at which those costs are escalating, the question could be asked -- does not society have the right to intervene when the behaviour of an individual devolves on others?

Government also faces another dilemma--the cost of providing traditional health care is such that it is very difficult to define the point at which funds can be diverted into comprehensive preventive programs.

Given all this, we stress again the importance of this conference which has as its theme "The Shifting Medical Paradigm: From Disease Prevention To Health Promotion". It promises to be extremely interesting and hopefully illuminating.

FRIDAY MORNING PLENARY

ABSTRACTS OF PRESENTATIONS

PERSPECTIVES ON HEALTH PROMOTION: POLICY, PRACTICES AND PROGRAMS

Dr. Maureen Law, Assistant Deputy
Minister, Health and Welfare Canada

The Health Promotion Directorate, Health and Welfare, Canada was established in the summer of 1978. It represents an effort to implement health promotion strategies.

It has two principle aims:

- To provide the public with information, materials and educational opportunities aimed at securing the adoption of healthy life behaviour for all Canadians.
- To encourage the development of social and institutional climates which in themselves are conducive to enhancement and maintenance of health.

Health Promotion Directorate has different strategies to acquire these:

- informing and educating the public and those who provide health and welfare strategies;
- encouraging the individual assessment of risks associated with various kinds of behaviours;
- encouraging earlier intervention in hazardous behaviours such as heavy drinking and smoking;
- advocating public policy that reinforces individual efforts in health promotion behaviour.

Seven priority issues to obtain results have been identified:

1. smoking
2. alcohol
3. drugs
4. nutrition
5. fitness
6. accidents
7. family and children's health care

Health Promotion Directorate projects are based on the following policy principles:

- They seek to achieve a balance between the individual and his or her lifestyle.
- They seek to promote restoration and maintenance of the individual's own health through self-care.
- They are associated with consumer interests.
- They seek integration between various behaviours, e.g., smoking/drinking/fitness/nutrition.
- They address themselves to the problems of special groups, e.g., socially and geographically isolated people, people in high risk places of work, people in low income brackets.

These principles serve two purposes:

- They give the Directorate a framework in which to develop projects.
- They permit the Directorate to communicate its intentions to individuals and groups in the country.

Costs here are not considered so important as in other areas of health care. The purpose of the Directorate is to enhance the health care of the individual as opposed to decreasing health care costs.

Examples of special projects are:

- Smoking - The project's aim is to produce a generation of non-smokers and to promote smoking cessation through such programs as the Pharmacy

Smoking and Health Program.

- Alcohol - Dialogue on Drinking and the Vancouver program, Skills, Preventive Control Drinking.
- Women and Addiction - a resource kit.
- Risk Assessment - Health Hazard Appraisal.
- Nutrition in the life cycle.
- Breast feeding.
- Fetal health.
- Stress Management - Stress Management in the Health Care Network; A Module for Community Health Care Workers and Family Physicians.
- Operation Lifestyle - a program designed to influence behaviours toward wellness in industry.

AN ECONOMIC PERSPECTIVE ON THE SHIFTING MEDICAL PARADIGM

G.B. Rosenfeld, Director, Special Projects
Health Services and Promotion Branch,
Health and Welfare Canada

- The shifting medical paradigm has a major effect not only on attitudes and activities of medical practitioners, health workers and governments, but as well on the individual citizen and family.

  These shifts when they occur are based not only on reason or cost/benefits, or changes in the state of the art, but on expectations of benefits and satisfactions. It is the sum of individual shifts both by providers and consumers that become recognizable in national economic terms. The fact that expenditure at present cannot be adequately collated on all aspects or parts of the paradigm and that values in economic terms cannot be properly placed on certain benefits raises serious problems for an evaluator who must endeavour to adequately report the overall benefits and total expenditures in dollar terms.

- New approaches in Health Promotion have been put into the market place and their values are being judged by those who eventually will decide whether they become fixed as integral parts of the paradigm as have prevention and care.

- A belief must be translated into fact and the wishes and hopes of an analyst, protagonist, or decision maker, should not be based on wishes and hopes but on as much fact as possible. Although wishes and hopes based upon preliminary findings will permit early funding there is often too high an expectation in terms of results or time to implement changes in technology, resources or approaches.

- There are at least four distinct human biases to note in evaluating a program:
    - the conceptualizer
    - the provider of the service
    - the consumer
    - the decision maker.

- While simply stated a positive cost/benefit finding indicates that the benefits to an individual or society are greater than the costs it should be noted that all costs to the individual and society must be incorporated as well as all the benefits. The difficulty in placing dollar values on the benefits is sometimes a philosophical problem.

- It should be noted that Engel's Law will affect the consumer "if there are costs to the consumer, the program will more likely become a disposable income class activity".
- The values that society place on well being and longevity need to be reinforced to create a favourable host environment; as the value placed on the benefits reflect societal attitudes.
- Agencies must note their interdependence and recognize that funds spent in one area are not available to another.
- By creating the most efficient and effective use of resources and interrelationships with allied projects one can increase the cost/benefit ratio.
- Cost/benefit ratios are only one input into decision making.

BIAS IN HEALTH CARE SERVICES

Dr. Sue Stephenson, Associate Professor
of Psychiatry, University of British Columbia
Faculty of Medicine

This paper identifies areas of bias in health care systems, and stresses the fear that we are on the brink of creating a new medical system which unites the new focus on individual responsibility for illness with the technological biases of biomedicine, ignoring or underemphasizing the social, the truly preventive, and the deeper roots of health and disease. New health promotion techniques are likely to perpetuate the old biases of more traditional medical care, and obscure the need for a major reallocation of priorities and a reorganization of health care resources.

The crisis in health care funding is causing cutbacks. But these probably will not restrict expensive technologies of dubious value. The most badly hit will be those groups who were never adequately served in the first place: the poor, children, mothers, the elderly and other minority groups. While the medical system is over-extended in many areas, there are shortages and inadequacies in needed services. Further investments in certain areas of medical care, such as maternal and child health would yield positive returns.

Despite universal medical plans, minority groups do not have equal access to medical care, get fragmented services, and meet biased and stereotyped attitudes from health care professionals. Medical care has largely ignored people's environment and its' role in health care. Medical care, developing ever more expensive technology, absorbing huge investments, is largely directed to patients who have multiple problems and short life expectancies even if cured of the immediate problem at hand. Enormous amounts are spent to delay the deaths of middle-aged and elderly persons -- mostly middle and upper class and mostly males -- a situation that reflects the anxieties of the health planners and physicians responsible.

Health promotion ideology, while purporting to focus on the environment, contains similar biases. It is more accessible and best suited to the healthy and wealthy. Moreover, it is a convenient way to rationalize cutbacks and blame the victims of chronic and stress diseases. It could readily become a shallow and simplistic notion which claims that we can stem rising disease rates by encouraging people to change the habits of a lifetime, rather than working to change those aspects of our society that promote the development of these habits as a response to intolerable stresses, degrading conditions and pervasive feelings of powerlessness.

TRADITIONAL HEALERS AND HEALTH PROMOTION: A CROSS-CULTURAL VIEW

Raymond Prince, M.D.
Mental Hygiene Institute
Montreal, P.Q.

In 1977, the World Health Organization announced that, in order to fulfil its pledge to provide health care for all by the year 2000, it would be necessary to encourage member governments to recruit indigenous health practitioners into their health systems. This was a remarkable about-face for WHO since, during its previous 29 years of existence, it had struggled to bring scientific medicine to the Third World.

This about-face resulted from a number of factors. Since the 1920's independence movements in many countries have led them to re-examine their own traditions and values, including their traditional health care systems. Beginning with China and India, and spreading subsequently to Africa and the South Pacific, many countries have encouraged investigation and gradual acceptance of their own health care systems and traditional healers. Concomitent with this, many social scientists have studied indigenous healing systems thereby rendering them scientifically intelligible. A number of investigators have confirmed the therapeutic effectiveness of traditional therapists and their techniques, and there have been a few attempts to develop cooperative ventures involving scientific practitioners with indigeous practitioners.

In spite of these developments, considerable controversy remains. Those who support the use of the traditional therapist emphasize: (1) his often greater acceptability to populations unfamiliar with scientific medicine; (2) the increasing expensiveness of scientific medicine as compared with folk systems; (3) that in many Third World countries there are far too few scientifically trained health personnel; (4) that in some areas, and for some conditions, indigenous practitioners are more effective than scientific practitioners. On the other hand, the following are some of the common arguments against the use of indigenous practitioners: (1) official support of folk healers will perpetuate magical world views and retard Third World development; (2) their use will perpetuate a two-tiered system of health care with scientific medicine for the rich and folk medicine for the poor; (3) some procedures used by indigenous practitioners are damaging (e.g., clitorectomy and uvulectomy).

INFORMATION NEEDS OF HEALTH MANAGERS

Dr. David Kinloch, Medical Health Officer,
Vancouver Health Department

> Upon this gifted age, in its dark hour,
> Rains from the sky a meteoric shower
> Of facts...they lie unquestioned, uncombined.
> Wisdom enough to leech us of our ill
> Is daily spun, but there exists no room
> to weave it into fabric; . . .
>
> Edna St. Vincent Millay
> *Huntsman, What Quarry?*

INFORMATION REQUIREMENTS FOR HEALTH MANAGERS IN RELATION TO THIRD AND EVEN TO SECOND PARADIGM OF ACTIVITIES

Unfortunately, we lack not only the loom but also the raw material of acceptable quality. We are poorly served by existing data sources - on the one hand, we are mislead or frustrated by the massive but not particularly helpful statistical outpourings of the Medical Care and Hospital Insurance Programs, and on the other hand, denied the depth of information regarding relevant population characteristics which was to have been accumulated by a continuing Canada health survey, now truncated by what is surely one of the best examples of myopic penny-pinching in recent memory. If we are to have an intelligence base from which to launch defensible programs, rather than simply to pursue our enthusiasms, we must have the organized ability to collect, analyze and integrate data regarding the physical and social ills of the population and the identifiable precursors of these ills. A good start would be to mount an organized effort to develop and continue the Canada health survey in the form originally proposed.

Information is not simply data or facts but rather knowledge gained as a result of investigation and study. The knowledge which health managers seek as a precondition for "promoting health" with conviction, relates to the validity or otherwise of the many unstated and untested hypotheses lurking behind the label "health promotion". How much is science? How much is wishful thinking; how much the premature application of the superficial and the trivial?

Other speakers have noted the long and honourable history of health promotion activities, dating back to Confucius and Hippocrates, but the most recent revival has occurred in response to a skillful refashioning of conventional wisdom by National Health and Welfare in their "New Perspective on the Health of Canadians". This new gospel sets out four major contributors to health - biology, environment, lifestyle and medical services, noting that the latter, while it has the least to contribute to alleviation of modern ills, consumes over 90% of the resources, at least visible resource devoted to so called health services. The case is made that it is the individual's own behaviour and choices which largely determine the illnesses and disabilities with which he will be afflicted and those to which he will succumb. This "diseases of choice" philosophy has inevitably lead to suggestions for "your fault insurance", with coverage extending only to those conditions over which the individual is said to have no control, and other "victim blaming" approaches. We are confronted with the possibility of Big Brother sneaking in the back door disguised as Big Mother. It may not however be so much the spectre of Orwell's 1984 as of Samuel Butler's Erewhon, where miscreants are regarded as ill and treated with sympathy and kindness, and the physically ill are regarded as criminals. Recent efforts by chemical manufacturers in the United States to defend against suits by diseased, disabled, or dead workers on the basis that it is not the negligence or lack of concern by the company in processing toxic chemicals, but rather the genetic deficiency of the individual that determined his fate, does not inspire confidence in the future.

In this respect, the "New Paradigm" is a subtle threat to the kinds of collective action that many believe is the only effective way to deal with what must increasingly be viewed as societally induced disease.

In looking back over the examples of successful "Second Paradigm" endeavours, it seems apparent that it is the passive rather than the active forms of intervention that have succeeded. Passive preventive activities result from implemented policies that result in subliminal protection of the public - chlorination of water; pasteurization of milk; in some more favoured cities flouridation of public water supplies; iodization of salt; fortification of foods. Future applications of this type would be a passive restraint system in automobiles. The aim is to obviate choices or decisions by the individual. Even the well intentioned and well motivated find it difficult to develop and maintain the necessary level of consistency. Automatic responses and unthinking behaviour are difficult to condition and maintain: you may brush your teeth everyday, but have you ever finished a course of antibiotics.

In reviewing our programs in the Vancouver Health Department, we propose to categorize them as (1) research, with the aim of developing testable hypothesis; (2) demonstration, where promising hypotheses will be examined under controlled or semi-controlled conditions, and (3) community application, either generally or aimed at specific sub-groups, of validated disease prevention or health promotion techniques.

There is now legitimate concern on the part of many regarding the lack of rigor and proposals for health promotion activities. It is time to sort out the testable hypothesis - indeed it may be lethal to the future of health promotion programming not to do so.

Those intent upon shifting paradigms might pause to reflect whether they are leaping from "mal" to "pire". The dominant paradigm operating on the medical model and comfortably attuned to its place in the "big paradigm" our Capitalist economy is doing quite nicely and although its voracious appetite for resources is never quite satisfied, it has not suffered from any marked shift of those resources to the competing paradigm. Given the economic news of the day and the pronouncements of government, it seems, at least likely that we shall be operating from a relatively fixed pool of dollars for "health services" and that support for prevention and promotion activities for the most part must come from redistribution. Whether sufficient support can be obtained even to adequately test promising hypothesis is questionable. It becomes a strategic question of whether to opt for the active or the passive route to seeking those resources. The active route would offer up a series of propositions for funding which might, if all goes well, stand or fall on their merits; the passive route would demand a major assault upon the dominant paradigm to obtain assured access to resources. Precedents exist: in Quebec 0.2% of the operating budget of the illness insurance program (Regie de L'assurance - maladie) is available each year to support fellowships; in some U.S. states, Alocholism Prevention Programmes are supported by a fixed proportion of tax revenues from alcohol. Thus, it might seem reasonable to propose that a fixed proportion of the Medical Care Insurance and Hospital Insurance program, or of sin-related tax revenue might be devoted to first testing and then supporting those means by which the health of the public might be promoted.

But while those of us attending this conference may be willing to shift our paradigms, most of those in position of influence are not, and they should properly remain skeptical until it can be demonstrated with more rigor than evidenced to date that we have the ability as well as the enthusiasm to intervene effectively. In these hype-filled days, an observation by Hemmingway may be apropos. Out of delicacy, I have used instead of Hemmingway's original descriptive term, the French translation as provided by the chief translator of the Supreme Court of Canada: "The most essential gift for a good writer is a built in shock-proof 'merdometre'. This is our radar, and all great writers and I would add (scientist, manager, politician, counsumer), have had it."

THURSDAY AFTERNOON SPECIAL SESSIONS

SUMMARIES AND INFORMATION ON COST-EFFECTIVENESS

HOLISTIC MEDICINE

Eike Diebold, Psychologist
The Psychosomatic Medicine Clinic
Gladman Memorial Hospital
Oakland, California

Education and Training

Up to this moment the main impact of our orientation towards the prevention of pathology is in education and training. Staff members of the Clinic consult public and private agencies for the purpose of establishing similar programs or for the delivery of intensive training programs to the staff of other facilities. Educational programs for the public are also conducted in conjunction with several universities and private organizations. In addition, the Clinic offers training seminars to health practitioners in the areas of Clinical Biofeedback, Autogenic Training, Acupuncture and the only recently introduced program in Holistic Medicine.

As these programs were formulated, the Clinic was inspected by the California Medical Association and accredited by the CMA for AMA Category I Credit; the California State Psychological Association and the California Nurses' Association for credit in continuing professional education.

The Procedural Format

The procedural format of the Clinic is as follows: the Clinic accepts referrals from physicians and other health practitioners or the patient may be self-referred.

As mentioned before, most of the treatment at the Clinic seems to be the correction of pathology. This however is not by choice but out of necessity. Many patients who come to us have some kind of disorder that has not been amenable to standard medical treatment. A potential patient either will call or drop into the Clinic to inquire about services and fees. A receptionist well-grounded in our philosophy and our services will take care of all the preliminary inquiries and will schedule a one-hour "intake" appointment to see one of the doctors who can be either a psychiatrist or a clinical psychologist.

The intake serves to evaluate the patient's medical and psychological history. The patient is asked to come about thirty minutes prior to the scheduled appointment so that he has enough time to fill out an extensive intake questionnaire. The purpose of this is twofold: it provides us with valuable clinical information and it will help the individual to collect his thoughts for the intake. The doctor and patient together decide on the treatment of choice: this can be stress management including biofeedback, counseling in nutrition and/or exercise. It also can be individual, marital, or cancer counseling, or a combination of some of these--any of the services the Clinic has to offer. And, of course, at times we do refer to other physicians since we in the Clinic do not engage in various aspects of traditional medicine, for example, we do not prescribe any kind of drug treatment. In the intake hour the patient is also informed of our clinical consultation meetings. They take place once a week, lasting for two hours. All members of the Clinic participate in these meetings; patients are discussed, including treatment, progress, and possible interventions. In this way the patient knows that the doctor who conducted the intake will continue to be in some kind of contact with him, even if this is only indirectly. After completion of the treatment, there will be a follow up at six months and then at one year.

Some of the Factors Involved in Promoting Health

Until relatively recently it has been difficult for most of us to look at optimum health without falling into the "health is absence of disease" model. However, in the light of increasing research findings, it becomes more and more evident that traditional medical systems affect only a minor portion of the generally accepted indices for measuring health, and that a major portion can be attributed to different factors over which physicians have little or no control. For example: Individual life-style, social support networks, physiological inheritance, and the physical environment.

In order to obtain optimum health, efforts have to be directed towards the following issues: modifying the individual's life-style, increasing meaningful social support systems, and, both on the level of the individual and society at large, improving the quality of our physical environment.

The discussion focussed primarily on where an individual can bring about change most effectively: his life-style. Recent studies on centenarian populations may give some direction in how to obtain life-styles conducive to optimum health. Researchers agree that nutrition, exercise, productive and meaningful involvement in family and community life seem to be of paramount importance in enjoying optimum health to a very old age. Being actively involved seems to be an important factor. And that is interesting, because many people today still believe that the most active thing they have to do in order to promote their health, is to visit health care professionals for treatment.

During the presentation, the eating habits of the average American were evaluated and alternative eating habits, conducive to optimum health were described. In addition to nutrition, there was strong emphasis placed on physical activity and a "Fitness Program to Benefit Most People". With the example of a case history, all the factors involved in optimum health were demonstrated most vividly.

And finally, to get a first-hand experience, participants were guided through a relaxation and imagery exercise.

NUTRITION'S ROLE IN AN INTEGRATED APPROACH TO HEALTH

Workshop Leaders: Joyce Mackay, Director Nutrition Education, British Columbia Dairy Foundation and Susan Ross, Community Nutritionist

A paradigm may be described as a fundamental image of the subject matter within a science - serving to define what should be studied, what questions

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should be asked and what rules should be followed in interpreting the answer obtained.

This workshop was designed to review the role of nutrition and the development of nutrition programs at four points along the continuum of the shifting medical paradigm: disease treatment, disease prevention, health prescription and health promotion. The Directory of Community Nutrition Services in British Columbia, (B.C. Ministry of Health publication, 1979, p. 28), handout provided examples of current programs, identified health problems and target populations within the disease treatment and prevention areas.

An attempt was made to examine the potential for providing a cost benefit or cost effectiveness evaluation of these nutrition programs since satisfactory data is not presently available.

It is a fairly straight forward task to tally the cost of materials and services provided by nutrition programs in the province. But it is difficult - if not impossible - to identify with any degree of consensus, the costs to our province of 'poor' health resulting from 'poor' nutrition. Without such information the benefit/effectiveness side of the equation cannot be accurately measured or valued.

The problems faced in calculating cost benefit ratios stem from a number of factors that include:

. information that is incomplete or contradictory. This problem is not readily resolved since nutrition is an aggregate science built on the evolving core of knowledge from a spectrum of separate physical, social and behavioural sciences. The fields of physiology, chemistry, biology, pathology, microbiology, medicine, agriculture and animal husbandry, public health, epidemiology, food production and technology, sociology, psychology, anthropology and education all provide basis for the theory and application of principles of human nutrition.

. available evidence linking health status and nutritional status of populations/individuals is, with the exception of specific diseases of nutritional deficiencies, primarily indirect evidence (i.e., by correlation or association) rather than direct cause and effect. While malnutrition is unquestionably a risk to which death and disease can be attributed, the constraints of human research and the variation in response to nutritional stress are amongst the factors that prevent assigning attributable risk under widely varying conditions of health, dietary intake and nutritional status. Attributable risk figures that have been reported are by necessity broad estimates that can be as easily challenged as supported.

. the cost of providing useful information (through surveillance or monitoring) for cost benefit statistics is likely to exceed its value, and the detailed nature of the information required may be regarded as an invasion of privacy.

Alternatives to a cost benefit approach included the selection of unobtrusive measures of data collection. Markers currently used to evaluate the effect of nutrition programs were discussed and summarized in a handout.

Nutrition education was considered a key component of an integrated approach to health promotion. Cost constraints demand efficient and effective programs, appropriate selection of target groups and a sharing of the financial burden between government, business and community groups. A review of the operation and evaluation of the B.C. Dairy Foundation school nutrition program and examples of print, radio and television promotion were used to illustrate the feasability of such an approach.

Submitted recommendations from the workshop leaders targeted three key populations for nutrition/health promotion programs - school age children, the perinatal period/young families, and the elderly - on the basis that such programs show reasonable short term and long term evidence of improving the health status of the population and of providing good return on dollars invested.

RECOMMENDATIONS

- That three key populations be targeted for nutrition programs:
  - perinatal and young families
  - school age children
  - the elderly

- That the school nutrition program be regarded as the primary health promotion so that in the future programs for young families and for the elderly will only be reinforcement programs and thus less costly.

- That each of the above programs be characterized by the following:
  - an effort to improve knowledge
  - alteration of the emotional and social support systems to make the environment more conducive to positive food choices
  - integration of effort of all health professionals
  - true assessment of the specific population and the specific community
  - involvement of the community (private and corporate) in the development and implementation of programs.

- That several communities be identified as trial communities to pilot health promotion campaigns and to identify significant markers for evaluation of subsequent programs.

- That the government(s) expand motivational campaigns to include not only fitness through exercise but also other parameters of healthful lifestyles choices.

TRAINING OUR DOCTORS TO BE IN HEALTH PROMOTION

Dr. Peter Grantham, Department Head
Family Practice
University of British Columbia
Faculty of Medicine

In British Columbia half the doctors are general practitioners. Traditionally no one existed at medical schools to represent them. At the University of British Columbia, a new department with a large mandate from community physicians, The Department of Family Practice, was established two years ago.

In the past, general practitioners were trained entirely by specialists; but the problems a specialist treats are different from the problems seen by general practitioners. The traditional and accepted job of physicians has been prognosis, diagnosis and treatment. This approach has generally worked well in the past and our medical schools continue to educate for this model.

Now the focus is changing. Doctors are espousing the "upstream concept"; they have traditionally dealt with problems after they have started. Currently, there is an attempt to increasingly emphasize preventive medicine and health promotion concepts in medical undergraduate teaching. Three medical practice paradigms are identifiable:

- disease/cure -- the historical model.
- disease/prevention -- a large part of contemporary practice
- identification of risk factors -- the "upstream concept". Health Hazard Appraisal is an example.

Precursors to some diseases (such as smoking/hypertension) for heart disease can be "diagnosed" and treated early, thus fulfilling the traditional physician role.

Medical education focuses on the development of three factors:

- knowledge
- skills
- attitudes

There is controversy about which area is the most important; knowledge keeps changing; the spectrum of disease changes. Perceptions about what constitutes disease differ among people and doctors.

Time lags occur:

- changes in the patterns of disease occur before society and its physicians notice the differences;
- new techniques to deal with contemporary problems must be developed;
- incorporation into the educational system of new knowledge and skills and attitudes takes further time;

The educational objectives of Canadian medical schools are:

- knowledge of patterns of human health and illness;
- the effect of psychological and sociological factors on illness;
- principles and techniques of disease prevention and promotion of health include, lifestyle change, behaviour modification, etc.;
- understanding of epidemiology, population and disease distribution;
- understanding health care delivery and our health care system;
- factors influencing compliance.

Physicians need skills in:

- adapting to changes in organizations, communities and cultures;
- identifying behavioural patterns that affect biological processes:"psychosomatic medicine";
- developing sensitivity and the ability to alter human behaviour.

Areas of special interest are developing in family practice, including:

- sports medicine
- behavioural medicine
- emergency medicine
- community geriatrics

A "behavioural medicine study group" consisting of a psychiatrist, general practitioner, clinical psychologist, social worker and nurses has recently been formed in the U.B.C. Family Practice department. It may be too early to tell yet, but if it proves worthwhile, a division of behavioural medicine may eventually be established. They are looking at questions such as: can consultation with behavioural therapists reduce health care costs? How do lifestyle factors relate to the incidence of disease? How do social factors relate to clinical presentations? How does community support affect the type of medicine practiced. Which professionals do what best? Who has the most effective techniques for common illness patterns seen today?

We continually move into new areas of medicine. We look at social, psychosomatic, behavioural and preventive medicine. It is probably premature to attempt to demonstrate cost effectiveness regarding professional practice patterns in these areas; validity needs to be demonstrated first, then general utilization, then incorporation into the educational system. This workshop was an attempt to develop increased awareness of the potential worth of preventive medicine and health promotion concepts and promote incorporation into medical undergraduate teaching. Cost effectiveness data may come with eventual changes in practice patterns.

PREVENTIVE MEDICINE IN PUBLIC HEALTH: BEHAVIOURAL MODIFICATION APPROACHES TO CHANGING DRINKING AND SMOKING HABITS

Dr. Lynn E. Alden, Assistant Professor, Community Psychology, University of British Columbia, Department of Psychology and Director, Preventive Control Drinking Program, Vancouver Health Department and Dr. Fredric Bass, Director of Health Promotion, Vancouver Health Department

An analysis of years of life forfeited by those who die before age 70 reveals, for Canada and for Vancouver, that behavioural risk-factors, especially alcohol and cigarette smoking, are the major preventive problems. The presentation describes how the SKILLS Program developed within the Burrard Health Unit in Vancouver to assist drinkers who are heavily at risk (more than five or six drinks per day) to reduce and to control their intake of alcohol. To complement the clinical approach described is an epidemiological view of host, agent, and environmental influences on the spread and control of risk-factor use.

Community health nurses and psychologists have been trained to assist patients to monitor their intake, to assess the positive uses made of alcohol and cigarettes, to find satisfactory substitutes, and to teach relaxation, assertive, or other specific behavioural procedures. Follow-up studies over the past three years have found that over 60% of initial participants maintain a reduced and non-risky level of alcohol intake.

Particular attention has been devoted to separating immediate behavioural change procedures from the later maintenance of newly-learned habits. For maintenance, self-efficacy - the individual's capacity to influence and to redirect their own behaviour - is of primary import.

Ecological interventions are described in the control of cigarette smoking:

Agent	. Cigarettes with reduced levels of tar, nicotine, and/or carbon monoxide; . Substitution of nicotine chewing gum for cigarettes; . Limited distribution (regulating supermarket, pharmacy and vending machine sales of cigarettes);
Host	. Psychological "Innoculation" to prevent onset of smoking; . Behavioural methods to facilitate cessation;
Environment	. Fostering the inhibiting effects of mandated No-Smoking areas; . Promotion of the increasingly popular cessation of smoking; . And redirecting governmental revenue sources away from their dependency on sales of harmful substances.

A joint clinical/epidemiological approach should enlist the support of a broad range of health professionals -- physicians, nurses, psychologists, health educators -- and of everyone else who is concerned.

RISK ASSESSMENT TOOLS IN HEALTH PROMOTION

Lynn Hawkins, Health Hazard Appraisal Officer
for Health Promotion Directorate,
Health and Welfare Canada

An examination of the natural history of disease, the progression to the concept of Wellness and the evolution of risk assessment techniques as the leading edge of patient/client counselling for the promotion of positive health practices. A practical and theoretical review of the Department's Health Hazard Appraisal program currently provided free of charge to counselling health professionals in business, industry and government health units. Details of its history, availability and application in a variety of health care settings will be discussed.

Participants at the session will have an opportunity to discuss the value and limitations of the appraisal system in light of their own personal appraisal results that will be provided by the Department.

HISTORY OF CANADIAN DEVELOPMENT OF HEALTH HAZARD APPRAISAL

Drs. Lewis C. Robbins, Jack Hall and colleagues of the Methodist Hospital of Indiana in Indianapolis originally developed Health Hazard Appraisal as a tool for physicians interested in the practice of preventive medicine.

Consistent with the aim of this discipline - to promote health and prevent disease - Health Hazard Appraisal assesses the lifestyle behaviours of individuals and identifies the odds of a person dying within ten years and identifies ways to change the odds in favour of that individual.

Health Hazard Appraisal not only helps to put lifestyle health problems in perspective but also provides a practical tool that teaches health workers as well as clients and can be used to motivate as well as monitor preventive action. It has a levelling influence because it emphasizes that how and when a person becomes ill or dies is, to a very large degree, in his own hands. It helps one see that he is his own best doctor and reduces the expectations by the clients and the physician that the health care system will be able to look after everything.

H.H.A. was introduced to the Department of National Health and Welfare in Canada in the form of an on-line computerized version that permitted a client to "interact" with the computer. This interactive approach was unveiled at the National Conference on Fitness and Health in Ottawa in December, 1972. Although popular, this system was complex and costly and was discontinued in favour of an inexpensive centralized batch processing system based on mailed questionnaires and returns.

Currently, the Health Promotion Directorate (formerly the Non-Medical Use of Drugs Directorate) provides the H.H.A. service to some 250 health professionals in Canada. These are health professionals associated with various federal and provincial organizations, industries, colleges, universities and public health units. Examples of organizational users of Health Hazard Appraisal are:

- Public Service Health Units, Medical Services, Health and Welfare Canada;
- Metropolitan Life Insurance Co.;
- GTE Automatic Electric (Brockville, Ontario);
- Procter and Gamble Cellulose (Grande Prairie, Alberta);
- Interior British Columbia Public Health Units;
- Peel Regional Health Unit (Brampton, Ontario);
- Employee Health Units (Edmonton, Calagary, Red Deer and Grande Prairie, Alberta);
- Nursing and medical schools at several Canadian universities and community colleges.

The usefulness of Health Hazard Appraisal is presently being evaluated. It has always been seen by Health and Welfare Canada as an experimental project subject to revision and further development. The Department has joined with two other providers of Health Hazard Appraisal - the Dalhousie University (Bodycheck) and University of British Columbia who have developed off-shoots of the federal program - to create a working group for this ongoing development.

This development includes revision of the operational components (input, processing and output) of H.H.A. as well as the development of new educational support materials. Research studies, designed to enhance the scientific basis of H.H.A., are also being undertaken by the newly formed

Risk Assessment Unit of the Health Promotion Directorate.

Some general comments relating to our experience with H.H.A. are in order.

- Health Hazard Appraisal appears to have a very limited value of its own. That is, it should be used in a setting where counselling and access to or information about various follow-up programs such as exercise programs, weight reduction clinics, or similar support are available.
- Non-specific factors are of extreme importance. For example, the attitude and especially the degree of enthusiasm of the nurse, physician or health educator can often overcome the benefits or deficiencies of H.H.A.

FOR FURTHER INFORMATION:

Health Hazard Appraisal
Risk Assessment Unit
Health Promotion Directorate
Health Services and Promotion Branch
Department of National Health and Welfare
9th Floor, Journal Building
365 Laurier Avenue West
OTTAWA, Ontario
K1A 1B6

ACUPUNCTURE AND THE BODY'S TROPHIC FACTOR

Dr. Chan Gunn, Medical Officer
Workers' Compensation Board and Faculty Member
Acupuncturist Foundation of Canada

Nothing may be taken for granted in life except death. Therefore the goal of medical science is not to produce immortality but to maintain optimum health until death. Ideal health is a state of complete physical, mental and social well-being and not merely the absence of disease. Usually it is not difficult to recognize overt illness, but there are many conditions which creep up on us insidiously to creat a state of sub-optimum health. Therefore today it is unsatisfactory just to prevent overt illness.[1]

Mere exposure of the human host to a specific agent does not inevitably produce illness. Illness is caused by the simultaneous interaction of host, agent and environment. This paper considers one important factor in the human host: specifically the nourishment of body tissues, or its trophic factor. Many factors play a role in the nourishment of the body's tissues. Activity is important and inactivity is followed by "atrophy of disuse" in muscle and bone. General factors such as diet and vitamins, endocrinological balance, adequate boood supply are others, but perhaps the prime factor in the regulation and prevention of trophic degenerative changes is on a neurologic and electric basis.[2] Denervated tissues soon lose their vitality, e.g., a denervated muscle shows a reduction in the amount of sarcoplasm, a loss of striation and an alteration in electrical responses. Whilst there are many neurologic disorders which may cause trophic dysfunction, there is one very common condition which is nearly universal - spinal spondylosis, or the progressive degeneration of the structures comprising the vertebral column. In the past this condition has been called osteoarthritis, spondylitis, herniated disc, etc., but spinal spondylosis is the preferred term as it is a degenerative rather than inflammatory or neoplastic condition.[3] Man, in adopting his upright biped posture has developed secondary curves in the cervical and lumbar regions which are subjected to increased movement or weight-bearing and the spinal nerves which emerge at these levels are more vulnerable to to damage leading to peripheral neuropathy or radiculopathy. Early peripheral neuropathy is generally unsuspected and unrecognized because it is "symptomless" and "pain-free"; pain only arising when (and if) the degenerative changes impinge upon pain-sensitive structures or upon pain fibers of the nerve. Because pain fibers are of smaller diameter than the other component nerve fibers, they are amongst the last to be damaged mechanically, hence pain is not always the "early warning signal" that we believe and so both patient and physician are oblivious to the condition. The term "prespondylosis"[4] was recently introduced to describe this insidious and progressive impairment of the comprehensive function of the peripheral nerve especially of its trophic aspect upon which the regulation of nourishment of all body tissues depends.

When discussing the spine, low back pain immediately comes to mind since it is a major cause of disability. However the low back is but one of many parts of the body affected by the spine. Many conditions presently labelled with non-scientific terms so as to imply specific clinical entities, e.g., "tennis elbow",[5] "bursitis",[6] "shoulder pain",[7] "trigger points",[8] and so forth are also secondary to changes in the spine. Because this fact is not as yet universally realized, there are untold numbers who suffer from unnecessary distress.

Peripheral neuropathy and chronic pain - acute pain or nociception follows the noxious stimulation of specific peripheral pain receptors and lasts for as long as tissue damage or inflammation are present. "Chronic pain" which persists when recovery should have taken place may best be explained by Cannon's Law of "denervation supersensitivity",[9] when the central perception of pain is probably caused by an abnormal input into the CNS from ordinarily non-noxious stimuli rendered excessive through overly sensitive receptors.[4] Thus chronic pain requires the pre-existence of neuropathy and supersensitivity.[10]

Peripheral neuropathy and degenerative changes - abnormally heightened autonomic pathways in neuropathy leads to increased blood vessel tone (constriction) of all tissues and can cause disintegration. Furthermore, following denervation, the total collagen in soft and skeletal tissues is reduced, the replacement collagen has fewer cross-links and is markedly weaker than normal mature collagen.[11] Since collagen provides the structural strength of ligaments, tendons, cartilage and bone this contributes to the many degenerative conditions in the weight-bearing (spine and intervertebral disc) and activity-stressed parts of the body (tendinitis, cuff tears, epicondylitis, etc.).[4]

Recommendations:

- Teach proper posture and correct mobilising exercises to all, beginning with pre-school children, to prevent vulnerable spinal segments from stiffening and thus entrapping nerve roots. Avoid prolonged bad postural positions (e.g., reading in bed, sewing, typing, etc.), by interspersing with mobilising exercises. Strenuous exercise techniques, e.g., jogging, are not suitable for everyone.

- Acquaint the public with the simple warning signs of prespondlosis-tenderness at motor points[12] and other early signs.[13] Introduce physiological treatment methods including mobilisation techniques, dry-needling at motor points,[14] (cheap and safe in the hands of trained nurses and physiotherapists).

- Conduct free public classes by paramedics or trained lay persons (paid or voluntary). Also, therapeutic classes using digital stimulation of motor points for pain relief by endorphin production.

- Conduct further epidemiological research into the relationship between prespondylosis, the trophic factor and other conditions, e.g., non-union of fractures, health of internal organs and body resistance to infections. The vitality of the reticuloendothelial tissues depends on the autonomic nervous system[15] and the effects of denervation supersensitivity are reversible by electrical stimulation,[2] an effective form of which is acupuncture, utilizing the current of injury. 16

The cost of the above recommendations should be negligible in relation to the vast potential gains.

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MEDICAL SELF-CARE: ACCESS TO HEALTH TOOLS

Dr. Tom Ferguson, Editor
Medical Self-Care: Access to Health Tools
California

Medical Self-Care

It has recently been noted that most people spend time treating themselves before they come into the physician's office. Self-care is one aspect of medical care and is receiving more attention today.

How does self-care relate to both traditional methods of care and holistic medicine? The following model will prove useful:

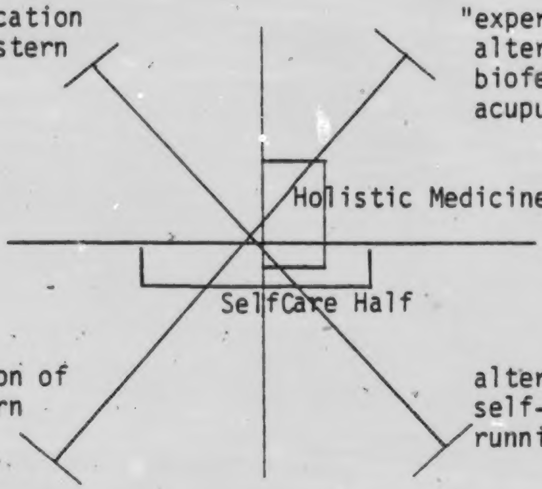
- Philosophical continuum:

Traditional approach — All alternatives

- Episodes of health care:

Modes of health care delivered by an expert — self-care

Put the two together:



- "expert" application of tools of western medicine
- "expert" application of alternative techniques, e.g. biofeedback, herbal remedies, acupuncture, body work
- self-application of tools of western medicine
- alternatives in philosophy but self-applied, e.g., meditation, running

Self-care for the individual is one level. Self-care happens on a social and community level as well. Self-care has been noted on five different levels.

- self as an individual
- family
- kinship groups; provide a huge range of self-care services
- self-help group-type 1-personal level; this is where people get together for the support of people in the group, e.g., women's groups, Alcoholics Anonymous, Parents without Partners.
- self-help groups - type 2-community and political level, e.g., anti-smoking initiative, nuclear energy groups - type 1 self-help groups can move into type 2 self-help groups.

Concepts of self-care can be summarized as follows:

Self-care Credo

- Health care is not only everybody's right but everybody's responsibility.
- Informed self-care should be the main goal of any health care program.

- Ordinary people, provided with clear, simple information, can prevent and treat most common health problems in their homes -- cheaper and sometimes better than doctors.
- Medical knowledge should not be the guarded secret of a select few but freely shared by everyone.
- People with little formal education can be trusted as much as those with a lot of education.
- Health care should not be delivered but encouraged.

David Werner
The Hesperian Foundation
Palo Alto, California
(Coordinator of the Mexico Self-Care Network)

FRIDAY AFTERNOON SPECIAL SESSIONS

SUMMARIES AND INFORMATION ON COST-EFFECTIVENESS

DEVELOPING SUPPORTIVE ENVIRONMENTS FOR CHANGE

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Human Resources Institute
Morristown, New Jersey

LIFEGAIN - A Positive Health Program

The Lifegain model is patterned on a system for cultural change called Normative Systems, developed by HRI Human Resources Institute in over 600 applications over twenty years. This system has proven its effectiveness as a change mechanism for numerous corporations, institutions, community groups and individuals. Lifegain applies the principles and techniques of this change process in a unique system which can assist people . . .

- by identifying harmful health practices supported by the group - corporation, community, family - that affect individual behavour
- by helping them to determine those factors that may be having a negative impact on health
- by providing an action plan for minimizing those factors, and where possible, changing them into positive behaviours
- by establishing support mechanisms to sustain the changes that are made.

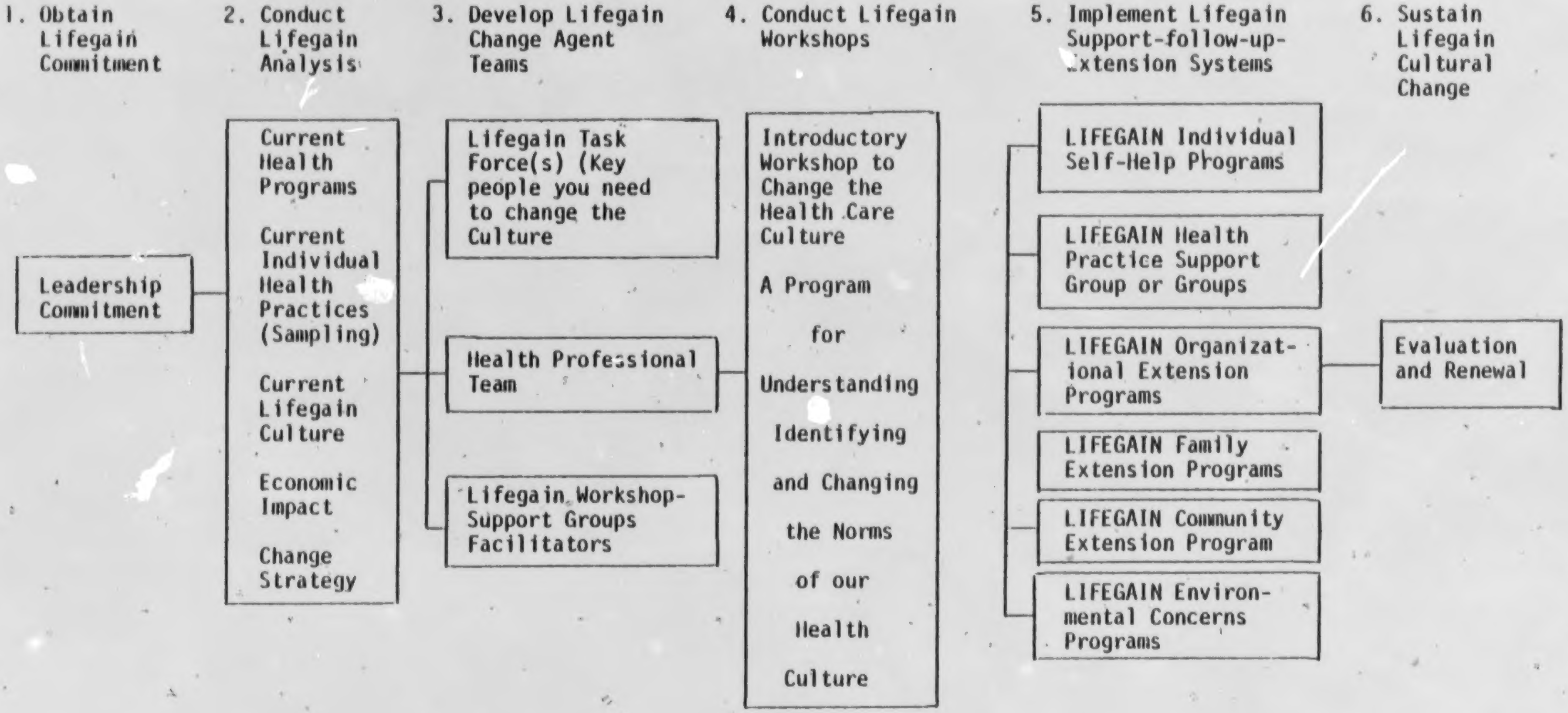
Lifegain offers a way that people can understand, identify and change those negative health norms formed by the many cultures to which they belong. These cultures -- our companies, families, schools, communities, clubs and religious organizations -- support a variety of negative health norms which are dangerous both to the individual and the organization. These negative health norms interfere with people's efforts that change and get in the way of maintaining improvement in health practices even after some improvements have been initially achieved.

Lifegain focuses on sustained cultural change. It was formulated through the combined efforts of nationally recognized physicians, specialists in preventive medicine, behavioural scientists and experts in group and organization development. It combines the science of "wellness" medicine with the behavioural science of change. And it makes possible sustained change both for individuals and for the groups that they belong to. Lifegain is:

- a program that brings people together to increase the quality and length of their lives
- a program to develop corporate, institutional and community health care cultures that encourage and support positive health practices.
- a program that emphasizes the physical fitness factors associated with the reduction of cardiovascular disease.
- a program that makes positive impact in such critical health areas as:
    - Physical Fitness
    - Weight
    - Smoking
    - Stress Reduction
    - Nutrition
    - Alcohol Abuse
    - Drug Abuse
    - Use of Medical Resources
    - Safety
    - Mental Health
    - Human Relations
    - Human Potential and Life Planning
- a program that enables individuals to choose a positive health program while helping to shape a supportive environment within the company, institution or community group.
- a program that is applicable to groups of varying size:
    - Corporations
    - Institutions
    - Communities
    - Churches
    - Families
    - Non-profit organizations
    - Schools

LIFEGAIN

HOW LIFEGAIN WORKS



1. Obtain Lifegain Commitment
   - Leadership Commitment
2. Conduct Lifegain Analysis
   - Current Health Programs
   - Current Individual Health Practices (Sampling)
   - Current Lifegain Culture
   - Economic Impact
   - Change Strategy
3. Develop Lifegain Change Agent Teams
   - Lifegain Task Force(s) (Key people you need to change the Culture
   - Health Professional Team
   - Lifegain Workshop-Support Groups Facilitators
4. Conduct Lifegain Workshops
   - Introductory Workshop to Change the Health Care Culture
     A Program for Understanding Identifying and Changing the Norms of our Health Culture
5. Implement Lifegain Support-follow-up-Extension Systems
   - LIFEGAIN Individual Self-Help Programs
   - LIFEGAIN Health Practice Support Group or Groups
   - LIFEGAIN Organizational Extension Programs
   - LIFEGAIN Family Extension Programs
   - LIFEGAIN Community Extension Program
   - LIFEGAIN Environmental Concerns Programs
6. Sustain Lifegain Cultural Change
   - Evaluation and Renewal

There are six essential steps in the program:

The first step is to obtain an informed leadership commitment to the program. Without such commitment it is very unlikely that any positive results can be achieved. To help gain this commitment, we have developed certain materials we think can help the leadership of the organization see the potential benefits that might be available.

The second step involves conducting an analysis of the existing health culture. This includes the examination of current health programs, current individual health practices, and the cultural norms affecting what is occurring. As a part of this analysis, the individualized change strategy is developed.

The third step is the development of internal change agent teams within the organization. Lifegain task forces are created, the health professional team is involved, and people who would be interested in facilitating the program throughout the company or group are recruited. This involvement of people is critical to the success of the program, since it is basic to our approach that the people most directly affected be in control of their own programs for change.

The fourth step calls for high involvement, introductory workshops where all of the members of the organization who care to do so have an opportunity to become involved in the process. These workshops, which run from two hours to two days, depending upon the time available and the purposes established, include films, presentations, participant goal setting, and individual and group planning. It is during this workshop that the various members of the organization have an opportunity to understand the cultural change program and develop a personal commitment to it.

The fifth step involves the implementation of support groups and extension systems. During this implementation phase participants are involved in individual and group self-help programs, in organizational and environmental task forces and in family and community extension activities.

Through the family and community extension programs, each individual Lifegain participant has an opportunity to invite members of his/her family to subsequent workshops and also to involve friends and community leaders from their various church, social and fraternal groups.

The sixth and final step involves the evaluation and renewal of the program. Participants are asked at the time of their involvement in the workshop to promise to periodically complete Lifegain evaluation forms that keep track of how they are doing in achieving the goals they have set for themselves. Regular renewal programs are held and presentations as well as newsletters are available. These help keep people abreast of new information in the health field and informed regarding successes that have been achieved.

We see this process as open-ended and supportive of individual freedom. Since many of the approaches that are used in the Lifegain program are different from those that are ordinarily in use in our cultures, people must have options, and people must be free to choose. People must set their own goals, choose their own levels of involvement, and select the materials, information and medical advice that is right for them.

If we are going to be effective, however, in having an impact on our health practices, then we are going to have to involve our corporations, our communities and our institutions bringing about change. Their involvement necessarily depends on the benefits resulting from such a cultural change effort over and above the prime objective of enabling people to live longer and more fruitful lives. Our experience to date has convinced us that there are some very real, practical benefits to such a program which are of substantial interest to participating groups.

For the business organization or institution, involvement in such a program can result in increased productivity and achievement on the part of the people in the work force, as well as in the lowering of health care and insurance costs.

For communities and community groups, the program offers an opportunity for people to come together to assist each other in achieving a shared goal. In this way, it helps build a sense of community while providing individuals with the tools needed to achieve better health and a longer life.

COST EFFECTIVENESS DATA

It is too early at this point to be able to provide an accurate measure of cost effectiveness. The program is relatively inexpensive to install, since it makes primary use of local resources. Preliminary indications are that sustained improvements in behaviours are being achieved. A carefully controlled fifteen year study involving an experimental and controlled community is scheduled to begin on July 1, 1980.

HOLISTIC HEALTH

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Until now, the Western system of allopathic medicine has been imposed upon all, including those people with distinctly differing belief systems and values. There is a realization beginning that this may be detrimental, that there may be value to the other beliefs and practices not only to those specific cultures, but indeed to the population at large. For example, Chinese medicine, Native Indian healing arts, Auyervedic medicine and others. This is not yet a dominant theory, but is gaining recognition and explorations are beginning to be made toward possible integration.

The exploration revealed a prevailing cross-cultural theory regarding energy systems. The present Western system is just beginning to research the meaning and implications of the energy phenomenon. This energy is known as Prana in Auyervedic medicine and is orderly within a Chakra system and it is known as Chi in Chinese medicine and is orderly within a meridian system; Qi in Japanese resembling the Chinese system; and bioenergy or electromagnetic field in Western science which can be detected/measured by machines such as the electroencephalogram (EEG), the Electrokardiogram (EKG), or the neurometer. Other cultures have other names for this energy.

It is difficult to explain the energy phenomenon in words for it is not yet clearly understood in Western science. It is believed that the dynamic homeostasis of this energy creates in the individual a status of immunological competence (health) and if imbalanced, a state of immunological incompetence (ill-health) results. A dual polarity exists at all times. Sometimes this is referred to as Eastern thought or mysticism. Dr. F. Capra, a high energy physicist, in his book The Tao of Physics, begins to correlate science and Eastern thought and mysticism.

It is more graphic to demonstrate how both physical and mental manipulation of energy pathways, points and fields produce a physical response in a human body. The demonstrations will illustrate how individuals unknowingly affect their own and other people's well-being in the sedation or tonification of the energy system.

NEW APPROACHES TO EXERCISE MANAGEMENT

Dr. Stanley Brown, Professor of Physical Education
University of British Columbia
School of Physical Education and Recreation
Gordon Stewart, Consultant and Writer in Health,
Fitness and Sports Conditioning

This presentation will deal with several topics and will include demonstrations. The topics are as follows: a) the use of simple and inexpensive (low technology) as opposed to complex and expensive (high technology), fitness testing; (b) the use of fitness test results in helping people to make decisions in directing their lives; (c) review of current exercise programs in the community; (d) presentation and discussion of a film about intellectual and emotional aspects of endurance running (e) approaches for improving structure and function which are not usually included (but should be included) in conventional exercise programs.

Cost and Benefits in Exercise and Fitness Testing Programs

Expensive medical procedures are often underwritten by governments or philanthropic organizations because they are the "best" ameliorative or diagnostic measures available. Here, humanitarian impulses can override cost-benefit considerations and this is one reason why we face the possible future bankruptcies of our medical schemes. With such prospects in view it is to be expected that governments would look cautiously at proposals for large scale preventive medical measures and would seek to know as much as possible about expected benefits in relation to costs.

Assessing costs and financial benefits of exercise programs and fitness testing is not yet an exact art. Costs will vary according to the extent and elaborateness of facilities, equipment and the kinds and numbers of people employed. Injuries and accidents caused by exercising would also have to be included in costs.

Benefits should be assessed over the long term, but because of the way we fund research almost all assessments of benefits from exercise programs are short term in nature. In estimating possible benefits for exercise programs and fitness testing procedures we have to rely somewhat on inferences about possible reductions in cost resulting from improved fitness levels. Some of the evidence is, however, based on studies of industrial or commercial exercise programs. The following describes some types of evidence about costs-benefits of exercise programs.

- Costs of premature heart disease in western countries are very high. Regular aeobic exercise would appear to offer prospects of substantial reductions in these costs. In Canada, loss to the economy of premature deaths from cardiovascular disease was estimated to be $1.7 billion in 1973 (1). The QUASAR Systems report (2) in Ontario, 1976, dealing with physical fitness and the cost of health care, reported several conclusions. An annual reduction in medical costs of the order $31 million would result if all those aged 20 to 69 years of age had an average level of physical fitness or higher. The sum quoted is equal to 5.5% of the $560.4 million paid out for medical services by OHIP for the period April 1973 to March 1974.

More specifically, in relation to CHD, the report concluded that a reduction of approximately $13 million in the expected total costs of CHD could result if all the people over 35 years of age had at least an average level of aerobic power.

- Estimates of savings to companies in reduced absenteeism for sickness and other reasons have been related to the behaviour of exercising and non-exercising personnel.

A 1977-78 fitness program and lifestyle education study done at the Canadian Life Assurance Company, Toronto, showed a number of benefits for the organization and its employees. Improvements in fitness, attitudes and personal relationships seemed to offer the possibility of positive long term effects on company operations. Absenteeism of participants was less than the seasonal trend for the organization and implied a direct savings in salaries per annum, for a company of 1400 people of $300,000. A significant lower staff turnover rate in the exercising group indicated an annual savings of $510,000 if applied to the company as a whole(3).

A number of reports from other countries show benefits in excess of costs for health programs in institutions or in industries which include exercise programs for employees. In Sweden, Kochum Mekaniska Varstads AB showed spectacular improvements in profits after instituting a company policy which included exercise for its employees (4). A Russian report(5) cites a variety of improvements in productivity, less vulnerability to accidents, less health care costs, reduction in time loss and absenteeism, resulting from general exercise programs in industry.

The total cost of absenteeism in Canadian Industry in 1977 was about $5.5 million, based on a work force of 9.8 million workers who averaged 12.7 absent days per year. Research shows that highly fit individuals have a lower incidence of absenteeism(6).

- Costs of back injuries in loss of productivity, loss of wages, medical expenses, and wage loss compensation of people while away from work is very great. It is likely that fitness programs in commercial and industrial enterprises would make substantial reductions in these costs.

  In B.C., in 1978, back injuries accounted for 21.3% of wage loss claims which amounted, in total, to $87 million. Wage losses represent only 57.3% of all compensation costs(7).

The costs to society of a relatively debilitated, unfit work force seem to be very great indeed and it would seem very unlikely that the costs of instituting exercise programs in business and industry would be more than a fraction of the benefits which could ensue. In instituting changes in order to save money, government faces a major problem in how to change the deployment of a large number of health care personnel from treatment to preventive services.

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PREVENTIVE MEDICINE IN FAMILY PRACTICE

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New developments in Preventive Medicine have taken place over the past several years. Risk factors have been discovered and/or are more clearly defined. We are more aware of the multifactorial aspect of disease(1 & 2). The behavioural sciences have developed new methods to assist patients in behavioural change.(3) This knowledge has resulted in the development of clinical procedures which can be used to prevent disease, treat medical conditions and promote health. The methods are applicable within a family practice setting. It is therefore now necessary to provide for:

- adequate remuneration;
- training programs for physicians and staff;
- support further research for the development and application of these methods.

A New Perspective on the Health of Canadians by Lalonde(4) and Healthy People(5) by the U.S. Health Education and Welfare, provide a clear concise statement of one major problem. In summary, the way we live (self imposed risks or lifestyle) is the major contributor to the leading causes of Death, Heart Disease, Cancer, Cerebral Vascular Accident and the major cause of Life Years lost. The main risk factors that can be dealt with by the family physician and his staff include - Smoking, Stress, Obesity, Inadequate Nutrition, Lack of Fitness, Compliance to Medical Treatment (Hypertension), Alcoholic Consumption. The need, however, is not only to prevent disease by modifying risks but also to focus on what constitutes health and promote activities that encourage it.

Another aspect of prevention is to detect disease early enough to effect appropriate sucessful treatment. This can be done for a few specific conditions such as hypertension, cancer of the cervix, cancer of the bowel, cancer of the oral cavity and glaucoma in limited populations.

For these few conditions, screening should be done on all patients.(6)

The following is a short list of therapautic measures which can be undertaken by the family practitioner and his/her staff. These are of major importance in disease prevention and health promotion.

Problem	Methods Used	Cost	Effectiveness*
Smoking Cessation	direct suggestion	$7 - $12.50	5-10% quit rate after 1
	hypnosis	$60- $200	20-50% " " " "
	Behaviour modification	$120-$250	25-50% " " " "
Physical Fitness	direct suggestion	$7 - $12	50% (well motivated group
	referral (e.g. YWCA)	$7 - $12.50	
	Counselling 1/3 sessions	$30- $90.00	
Dietary Counselling	diet recording, analysis and feedback behavioural model	$30 session for 2/3 sessions	unknown
Weight Control	behavioural approach to eating habits, diet and exercise	$30/session 10-20 sessions	5-30% average is likely 7.5% for long-term
Stress Management	behavioural approach to relaxation training, cognitive restructuring and environmental change	$30/ session 3-12 sessions	40-90% success in insomn anxiety, phobias, tensio headache, migraines, hyp tension, etc. As a prev tive measure the results are unknown.

Health Screening	blood pressure, Pap test, Stools for Occult blood, smoking alcohol, weight, breast exam, rubella titre, testicle exam, cholesterol, VDRL, Tonometry, stress, fitness, nutrition, seat belts, retirement	$12.50-$30 session plus lab costs to be done every one to two years	effectiveness generally agreed on for most of the items mentioned. (5 & 6)

*Effectiveness -- estimates from the literature review and clinical practice.

Most sessions would be billed at $30.00 per ½ hour session. Except for weight control, all costs should be easily recovered by fewer sick days, savings in food costs, savings in cigarette expenses, as well as increased productivity, and above all, increased health and well-being. It should also be pointed out that the cost is low, and does not require high cost medical technology. When disease is treated and prevented at the primary care level, it is dealt with effectively and at a reasonable cost. All efforts should be directed towards keeping health at this level thus avoiding referrals to high cost secondary and tertiary care.

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THE INDIVIDUAL/ENVIRONMENT SYSTEM: TOWARDS AN UNDERSTANDING OF RESPONSIBLE AUTONOMY AND HEALTH

Ken Low, Director of Action Studies
Calgary Board of Education

Quality of life is an interactive system of the individual and the environment. Beyond a certain point, quality of life cannot be significantly improved by developing the environment alone -- the capacity of individuals to act within that environment must also be developed.

The most notable quality of life developments in history have occurred in the past 120 years due to dramatically increased understanding and operational capabilities set in motion by the industrial revolution and the first mass information technologies -- powered presses. Most of these epoch-making quality of life developments resulted from changes in the environment; control or even elimination of pathogenic organisms, substantial improvement of social economies, and improvement in the quality, stability and variety of available food supplies. These changes have not been accompanied by corresponding improvements in the capacity of individuals to act.

Health problems arising from "lifestyle" are symptomatic of our current major quality of life problem -- equipping individuals with adequate levels of responsible autonomy.

Through the past ten years the Action Studies Group of the Calgary Board of Education has been developing both descriptive conceptual frameworks and programs in the area of personal competence or responsible autonomy, with funding assistance from federal and provincial governments. There is still a very long way to go in understanding the dynamics of responsible autonomy and how it is nurtured and supported, however some of the basic elements and principles seem clear.

To begin with there are no existing social formations that consciously and systematically nurture responsible autonomy. We have in the past done well enough by nurturing social competence -- or the ability to carry out actions embodied in routine social roles. This approach worked because of the slow rate of change and high rate of contextual limits to quality of life, which were largely independent of personal action.

We are now, for the first time in history, having to examine how to systematically develop generic skills or the higher order non-specific skills that are used to create actions -- the skills that make up responsible autonomy.

Many of the existing child nurturing arrangements, including much schooling, do more to undermine responsible autonomy than to develop it. Health professionals, and others concerned with human development should understand that there is a major "systemaic" problem with schooling and education in general, and that adding new curriculum units in existing learning formats will do little or nothing to improve the personal competence levels of children.

With this introduction, the session goes on to examine some of the characteristics of personal competence.

> Personal competence may be analysed in terms of powers of change or the ability of an individual to produce and/or live with change. The personal basis for exercising and developing one's powers of change is the creation of experience.
>
> Personal competence is a meta-state or open-ended process wherein individuals take the major responsibility for the exploration, development and maintenance of their own powers. It does not imply the absence of problems.

Powers of change are of two basic types, ordering and tolerance with accommodation being the hybrid of these two.

Careful decisions about what is worth doing are based on a balance of three distinct criteria (1) what experience does it produce; (2) what else could have been done from the same starting conditions; and (3) what significance does it have for possible future experience - i.e., does it have positive, negative or neutral effects on one's powers of change.

The ability to act is multi-dimensional, involving abilities of intention, formulation and operation. These abilities must be developed in a balanced relationship to each other - something that typically does not occur in formal education.

There are two orders of generic skills that can be identified using a simple "calculus of action" based on hows, ways and whys of action. Level one generic·involves nine different combinations, such as knowing how to know how or knowing how to know why. Level two-involves 27 combinations of high order generic skills such as knowing ways to know why or how to know how to know how. Personal competence requires at least some ability at each level.

Design for personal competence development requires: variety of experience with "real" situations, reflection or analysis to identify common principles, invention or synthesis in creating new actions.

Apart from direct experience people learn about powers of change by observing others. The "diet" of people watching

> in North America today is terribly imbalanced owing to the type of media we have and the fragmented living, working and learning arrangements.
>
> Many of the living and learning arrangements developed in the past four decades undermine and limit individual powers of change.
>
> Extensive institutionalization and ghettoization of populations is very likely to limit or degrade individual powers of change and foster high rates of self-defeating behaviours at the boundaries of institutional control.

The Action Studies Group has been developing programs based on the type of analysis presented here. These programs address subcomponents of the personal competence/environment system and no summative evaluation is yet possible - though formative evaluation is ongoing. Cost effectiveness calculations are difficult to make. It is certain that the costs in terms of efforts, resources andadjustments will be very great. These costs are mitigated by the fact that the proposed developments are in line with out historical development - and we have to be doing something with ourselves anyway. On a large scale the major alternatives appear to be (1) to do nothing, (2) to shut down the illusion of freedom and develop an effectively regulated paternalistic society or (3) to seriously develop responsible autonomy on a mass basis. Given the probable costs of the first two alternatives, the cost of the latter seems quite acceptable.

A HOLISTIC APPROACH TO CHRONIC PAIN MANAGEMENT

Dr. Charles Gregory, Director, and
Dr. John Satterberg, Psychologist
Columbia Pain and Stress Centre, Vancouver

Chronic pain is a totally different phenomenon than acute pain, yet the prevailing attitude towards its management is that chronic pain is merely an extension of acute pain, and therefore the basic management approach should be the same. Evidence gained over the past fifteen years from a number of syndrome devoted exclusively to patients with severe chronic pain has shown that this is 180° wrong, that the chronic pain programme has a dynamic all its own, and that the nature of pain experience is grossly misunderstood.

Pain, whether acute or chronic is never simply a sensation from the body to the brain: it always contains a learned component - i.e., the meaning of the pain is an important factor in the way in which pain is experienced, and pain is therefore an experience, not a sensation, which involves the entire person, physically, emotionally and mentally.

In acute pain the sensory component generally far outweighs the learned factors, but the more chronic the problem the greater becomes the significance of the latter. It is therefore, irrational and ineffective to treat chronic pain in the same way as the acute variety. In fact, the use of acute techniques for chronic pain are not only not indicated: they lead to a worsening of the problem in many cases.

It is imperative therefore, that the whole person be considered, not merely the physical factors, and the Columbia Centre Programme is based on this concept. It involves intensive physiotherapy, biofeedback, medication withdrawal, relaxation training, autogenics, educational lectures, various forms of therapy including emotional, marital, sexual and vocational, hypnosis if indicated. Experience has shown repeatedly that the most significant person in a patient's life must be involved both during the residential programme and after. We regard this as being so important that we make it a condition for admission to the Centre.

From what has been said, it is obvious that we believe that significant life-style change is the only way this kind of person can learn to live a fully enjoyable life with or without pain. We can only begin this process during the six weeks residential programme, and we recognize that it takes far longer than that for people to incorporate it into their daily lives. Thus we have a follow-up programme, which as far as we are concerned, is unique and continues for 18 months, after the patient has completed the intensive six week phase.

COST EFFECTIVENESS OF THE CHRONIC PAIN PROGRAMME AT COLUMBIA CENTRE

It must first be emphasized that the patients who are referred to Columbia Centre Chronic Pain Programme are by definition chronically disabled, and almost every single one has been out of work for a minimum of a year, and some for eight, ten or more years. They therefore constitute a continuous drain on the economy, both now and for the foreseeable future.

Costs both to patients and insurance carriers are divisible into medical costs and wage loss costs, actual or projected.

Hospital costs at Vancouver General Hospital are currently $355.00 per day, which generally does not include payment of physicians. Patients are referred to a programme because their pain has resisted all attempts to change it, and generally have had at least one, and often several operations, but still have their pain. Their medical costs alone have been invariably in the thousands, and with no end in sight for the insurance carriers.

Future Wage Loss

Two examples will give the picture. A.D. suffered back injury, had three operations with no relief, and eight and a half years later, was in worse shape than ever, having been unemployed the whole time. He had therefore cost the Workers' Compensation Board eight and a half years of wage loss payments, and since he was only forty-two, was eligible for a further twenty-three years of this support. In wage loss alone, therefore to say nothing of the hospital and physicians' costs, he must have cost the Board an absolute minimum of $100,000, and the probable outlay over the next twenty-three years would (even at present levels), have cost about $250,000. The cost of the programme at Columbia Centre for this patient was just under $11,000.00 and he has been working since he was discharged.

In accidents covered by other insurance carriers, there is a minimum wage loss paid of $1,000.00 per month, thus every month by which return to work is delayed costs $1,000.00 Judgements in accident cases are partly determined by the calculation of future wage loss, and thus for a person of 55, the carrier faces another ten years of wage loss amounting to $120,000.

With figures like these, cost effectiveness can hardly be in doubt.

EXTENDING HUMAN CAPACITIES: PSYCHOLOGICAL, PHYSICAL AND SPIRITUAL

Dr. Lee Pulos, Clinical Assistant Professor
Department of Psychiatry
University of British Columbia

New ideas on energy healing, spiritual healing and psychic surgery are becoming more and more evident. Our ideas on time and space are being challenged These ideas are based on two key positions.

- The key to our self understanding lies in the para normal, in things such as energy healing materializations. Many para normal events are not beyond science but rather "para conceptual", that is beyond our understanding. Most of us live in a cultural trance. We limit our experiences to our five senses and to linear time. This is not so in other cultures and even in children.

- Many phenomena that used to feel uncomfortable to science are now comfortable and familiar. For example, Yogis claimed control of involuntary processes. Their ideas were viewed with skepticism; now they are more acceptable. Other practices fall into the same category: biofeedback, hypnosis, Freud's concept of the unconscious, psychosomatic illnesses, psychic and consciousness research. These and other baffling ideas such as telepathy and precognition that used to be uncomfortable, are now moving into the comfort zone. Psychokeneis (mind over matter) claims that the force of wills can affect matter. Human subjects by their own volition can bend, stretch or twist metal. These are the so-called Geller kids.

The ultimate psychokeneis is biological psychokenesis or energy healing. Energy healing is based on the following principle: energy can have a positive or negative valance. One area of scientific discomfort is psychic surgery and energy healing. How does this work? What effect do utilization of energies have on healer/patient relationships?

Two things are common to all energy healers:

- materializations
- trance.

Materializations

Materializations are a series of visual effects that dramatize the healings. They are key to understanding these phenomena. There is a definite interaction of consciousness with matter to produce these strange things. A common technique in the Phillipines provides a good example. The patient lies down, no shirt on, the healer makes a kneading motion on the patient's skin somewhere and suddenly matter will appear. Rarely is there an opening. Tissue materializes through the skin. Sometimes it is tissue, sometimes it is blood of various colours, sometimes it is not human tissue or blood. It is not palmed. It is almost instantaneous. These phenomena have been studied under controlled conditions by western scientists and shown to be valid. Their healing effects, however, have been questioned.

Trance

A state of trance is common to all healers. There are many kinds of illnesses; physical, mental or spiritual which can begin at any level of consciousness. These healers can transcend ordinary consciousness and tune into various bands of consciousness.

Our consciousness knows no limits. Our levels of consciousness can alter states of being. For example, a change of consciousness can participate in energy "Frequency domains" and reorganize the atoms in an object. Spoon bending and materializations work like this. Materialization is the interaction of two consciousness fields, those of healer and healee.

RECOMMENDATIONS

INTRODUCTION TO RECOMMENDATIONS

An important objective of the conference was to generate recommendations which could be used as a focus for future work in health promotion.

Recommendations were gathered from two sources: panel speakers and general participants. Each of the eight panel speakers submitted one recommendation which related to the theme of the conference and to their panel topic. Following the conclusion of the panel presentations, participants were divided into eight recommendations special sessions, each led by a facilitator and a recorder. Participants were instructed to think about the recommendation, and to either accept it as worded, reject it as worded, or amend it. Once agreement had been reached regarding the content of the statement, the group developed steps to implement the recommendation.

At the conclusion of those small group discussions, the results were reported back to the plenary session.

Essentially, these sessions were designed to accomplish the following:

- provide participants with an opportunity to participate actively in the conference;
- teach people to think critically about the content of recommendations and to think through the structure of a useful recommendation; and
- to provide the conference planners with the benefit of the participants' knowledge regarding steps to implementing recommendations.

During the first day of the conference, participants were asked to submit their own recommendations. These recommendations were sorted according to the following criteria: major health categories were covered; statements were clear, and specific and task-oriented, and duplications were deleted.

In all thirty-eight recommendations were received from the floor. Of these, nineteen duplicated areas which had already been covered in the panel speakers recommendations, three of the suggestions related to work already in progress. Four were rejected as being nonspecific.

The second day of the conference, participants were asked to rank the top five recommendations from each of the two sets of recommendations: those received from the panel speakers, and those received from the participants. The resulting ten recommendations were reported to the plenary session.

These recommendations were then submitted to an Action Group comprised of senior officials representing federal, provincial and municipal health ministries and organizations, medical associations and universities. The purpose of this group was:

- to match individual recommendations with appropriate ministries, agencies or other groups;
- to develop appropriate action strategies which would secure implementation of the recommendations.

RECOMMENDATIONS

Recommendations from the Floor: Asterisked recommendations are those which were given top priority by conference participants and were forwarded to the Action Group.

* a. An interdisciplinary task force undertake a controlled research study in a selected B.C. community (with appropriate control communities) to study the impact of a concentrated health promotion program including increased communication and collaboration among health professionals, and a detailed baseline study of the community's health status and needs, and a variety of short-term intervention/education projects. Establishment of the task force and selection of a model community should be completed by December 1980 and a final report of the community study should be completed by December 1983.

*b. The B.C. Medical Association establish a committee to draw up a fee structure for preventive and behavioural medicine in '80-'81 and negotiate this fee structure with the government in 1981.

*c. Training programs for health professionals devote at least 25% of their curriculum to learning/teaching health promotion techniques by September 1981.

*d. Since healthy life-styles must be developed from birth, and since parents are the most influential agents in a child's life, that a multi-agency task force be established by December 1, 1980 to determine effective ways of involving parents in self-care and health promotion strategies for the family (particularly those parents who would not normally avail themselves of such programmes). This task force will report its findings by December 1, 1982.

e. The Ministry of Health give legal sanction/promotion to the institution of the practice of midwifery by qualified nurse-midwives by December 1981.

*f. The B.C. College of Physicians and Surgeons change their policy regarding home-births, to allow physicians to attend home births without fear of losing hospital privileges, and to promote birth as a natural event in family health, as opposed to an institutional event which often creates trauma.

g. That the universities (or other suitable institutions) begin to offer formal degree programs in Health Education at the Bachelor's level.

h. The B.C. Ministry of Health established a co-ordinator of "Fitness for Seniors" (holistic medicine, etc.).

i. A joint Federal/Provincial Committee study the whole question of food additives and preservatives, as well as current farming techniques and insurance programs which discourage organic farming and report its findings by December 1981, to their respective Ministries.

Panel Speakers Recommendations:

* a. Educational, service and research institutions should explore in depth the concepts and practices which are commonly related to Holistic Health; those aspects which prove potentially helpful to the present system should be identified, further studied and integrated at all levels of health care services and education.

b. Provincial licensing and registration acts for health professionals, should be amended to support the efforts of the World Health Organization to optimize the use of traditional healers in health care and disease prevention in areas where "scientific" medical resources are inadequate and where folk medicine practices do not violate medical ethics and/or human rights (e.g., in parts of Africa both clitorectomy and uvulectomy are still common-place procedures).

* c. The hospital and medical care insurance systems should devote a fixed proportion, say 2% of their total operating expenditures to elucidating health enhancing measures and those measures which survive sceptical scrutiny should be financed and promoted from the above sources.

* d. Relevant professional associations should establish a joint task force to prepare and present a report by January 1981 to the citizens of British Columbia on the health status of citizens of B.C. The report should outline health improvement goals for the next twenty years. It should be based on input from relevant ministries, industries, agencies and citizens.

e. Professional health associations should recognize the expertise of qualified non-physician practitioners of holistic medicine by including them in health insurance plans.

* f. Minority group needs are likely to be lost in a health care philosophy that stresses individual responsibility for lifestyle. Policy makers should give more attention to social and cultural factors in planning health services for minority groups, especially Native Indians and the poor, and special attention should be given to the needs of children and women.

* g. Our Educational System should take leadership in modelling and teaching postive health practices to children. These practices should be an integral part of all school curricula, rather than taught in a fragmented manner.

h. Proposals for new voluntary and government initiated health-promotion projects should include a model for evaluation including cost-benefit. However, demands for evaluation made as a condition of funding, should not exceed the demands which are placed on disease treatment programs.

POST CONFERENCE ACTION GROUP REPORT AND ACTION PLANS

RECOMMENDATION

Education, service and research institutions should explore in-depth the concepts and practices of Holistic Health: those aspects which prove potentially helpful to the present system should be identified, further studies, and integrated at all levels of health care services and education.

RECOMMENDATION

The hospital and medical care insurance systems should devote a fixed proportion, say 2% of their total operating expenditures to elucidating health-enhancing measures and those measures which survive skeptical scrutiny should be financed and promoted from the above sources.

The Action Group considered these two recommendations together. They felt that action on the second recommendation, the suggestion that medical care insurance systems devote a fixed proportion of their income to elucidating health-enhancing measures, was a more long-range goal dependent upon the successful implementation of the first recommendation. Based upon this assumption, an action plan was developed in an effort to implement the recommendation suggesting education, service and research institutions explore in-depth concepts and practices of Holistic Health.

A problem identified during the discussion was the development of an artificial dichotomy between the traditional medical paradigm (paradigm 1 as identified by Mal Weinstein in his presentation) and the more recent medical paradigms (paradigm 3 as identified in the Weinstein paper). The major difficulty in integrating ideas, ranging from health education and promotion to trans-cultural alternative healing practices, is the breakdown in communications between the proponents of the different paradigms.

Examples of this include a reluctance on the part of some parts of the traditional health care system to examine innovative healing techniques or to place a strong enough emphasis on the preparation of medical personnel in health promotion and prevention procedures. In turn, advocates of some of the holistic approaches often reject outright the scientific method as a means of establishing the validity and usefulness of their ideas. Thus, new health approaches are not always subject to the kind of scrutiny which can validate their importance and strengthen their development. In turn, the traditional health system does not take advantage of all the tools available in its fight to promote health and cure disease.

With this general discussion as background, the Action Committee decided to establish a task force which would focus on the interface between the proponents of the different medical paradigms in the Province of B.C. and to identify ways in which obstacles to communication could be removed and the common ground between approaches identified. The focus of the task force will be on examining strategies to improve the interchange so that both the traditional education service and research institutions could be strengthened by incorporating concepts of Holistic Health and the Holistic Health movement strengthened in its evolution by contributions from the more traditonal health field.

Action Plan

As the first step, the task force will meet on Friday, April 25th at the U.B.C. Faculty Club at 3:30 p.m. The purpose of this first session will be to determine a frame of reference for the operation of the task force, to discuss a possible addition of members, to develop a plan of action and to divide the responsibilities for implementing such a plan.

The Committee felt that it would be a mistake at this point to try to make the task force a functional part of any government agency. Instead, it will consider itself answerable to the Conference Action Committee. While requests for funding might be appropriate at some future date, at this point, the discussions of the task force will be on an informal basis. This will allow members to participate in an unofficial capacity rather than as representatives of their departments and agencies.

Progress Indicator:

Progress would be indicated by the completion of a written frame of reference for the task force, identification of its membership and the development of a plan of action for its first year of operation. While the action group did not develop specific plans during its first meeting, the following suggestions indicate the type of activities the task force might either pursue or encourage. One such suggestion was to attempt to influence funding agencies to give special support to researchers within the traditional system and those associated with the Holistic Health movements, who would like to explore the effiacy of Holistic Health approaches. A second idea was to encourage agencies to strengthen the research methodological supports available to practitioners in Holistic Health which would enable them to implement sound research designs. A third suggestion was to survey the state of the art of Holistic Health and develop clear guidelines for describing the various approaches in the field (e.g., health promotion activities, acupuncture, stress reduction). A fourth idea was to encourage a survey which could identify ideas generally associated with Holistic Health practices which are already being implemented within the traditional health system. Finally, the task force could facilitate the development of a unit of an educational/research institution to undertake implementation of the proposals contained in the general resolution.

Task force members are encouraged to consider the task force composition, the framework for operation and specific suggestions for the future activities of the task force in preparation for the meeting on Friday, April 25th.

Group Recorder: Dr. Lawrence Shulman

RECOMMENDATION

The B.C. Medical Association established a committee to draw up a fee structure for preventive and behavioural medicine in 1980-81 and negotiate this fee structure with the government in 1981.

Action Plan

To develop by a committee, a structured format for provision of primary and secondary health services in family physician practices.

By Whom and When

Guidelines are to be developed by the B.C.M.A. and the payment agency, i.e., the Medical Services Commission. They would have to agree on the fee and guidelines for implementation and control. Implementation should be by May 1981 as measured by a report to the general assembly of the B.C.M.A.

Group Recorder: Dr. Mel Petreman

RECOMMENDATION

An interdisciplinary task force undertake a controlled research study in a selected B.C. community (with appropriate control communities) to study the impact of a concentrated health promotion program including increased communication and collaboration among health professionals, and a detailed baseline study of the community's health status and needs, and a variety of short-term intervention/education projects. Establishment of the task force and selection of a model community should be completed by December 1980 and a final report of the community study should be completed by December 1983.

Action Plan

An interdisciplinary task force be assembed to identify appropriate communities for controlled research studies. The task force will:

- set parameters for study
- identify and study control communities
- involve local community in design and implementation of the study
- obtain funds

The implementation group will:

- undertake a baseline study of the experimental and control group's health status
- determine the health needs to be studied
- test a variety of short term and intervention strategies
- conduct a study on the impact of a concentrated health promotion program including increased communication and collaboration among health professionals.

By Whom and When

- Executive Director of Health Promotion Directorate, B.C. Ministry of Health be asked to appoint and fund a small working group including one staff member to initiate this plan by September 1, 1980.
- task force should be assembled and steps a-d implemented by December 1, 1980
- series of short term strategies should be completed and reported by December 31, 1986, (a short term study - 5 years)
- long term outcome measures should be studied (10 - 60 years)

Group Recorder: Dr. John Milsum

RECOMMENDATION

Minority group needs are likely to be lost in health care philosophy that stresses individual responsibility for lifestyle. Policy makers should give more attention to social and cultural factors in planning health services for minority groups, especially Native Indians and the poor, and special attention should be given to the needs of children and women.

The recommendation was accepted in the following amended form which represents a statement of philosophy:

> "A health promotion/prevention philosophy that stresses individual responsibility for healthly lifestyles must address the economic, cultural and social disadvantages that prevent many people from living, as well as choosing to live, a healthy lifestyle."

A plan of action was derived from this statement. Given the problems addressed by the intent of the original recommendation, however, the above "philosophy" and the following plan of action were considered too vague at the present.

The first step, therefore, is to establish a working committee from this planning/action group to elaborate on this recommendation and its policy implications, and produce a more comprehensive and lucid statement within two months.

Action Plan

1. That the planning committee of this conference present the recommendation to the Ministers (federal and provincial) of Health, and their Program Directors of Health Promotion programs. (A possible vehicle for this may be the Federal/Provincial Advisory Committee on Health Promotion.) The two levels of government then have six months for the consideration and adoption of the health promotion philosophy, with the following program implications:

2. Monies be allocated by both levels of government to "disadvantaged groups"
    - women
    - children
    - Native Peoples
    - new immigrants
    - the poor
    - workers (with respect to occupational health)
    - the handicapped

   to study and define their health needs. Monies to be released by January 1, 1981; studies to be completed by January 1st, 1982. While the criteria for allocations of funds are yet to be determined, it is possible that various activist groups representing the above list will be utilized, as they have already analyzed to some extent the peculiarities of their health needs.

3. Consultation will then take place between these groups and all government departments affected by their self-defined needs.

4. Government policy analysis based upon these needs, and understood within a health care and promotion philosophy that acknowledges the importance of economic, cultural and social constraints on individual health, will be completed within a specified time arrived at by group/government consensus.

5. This will be followed by distribution and public discussion of the detailed policy analysis.

6. Mechanisms will then be established for the full participation of these "disadvantaged groups" in the formulating, monitoring and implementation of policy.

7. Mechanisms will also be established for dialogue between "disadvantaged groups" and health care workers, notably physicians.

Sample outcomes discussed:

- . Sustained funding of lay and paramedical self-help health groups.
- . Committees of "disadvantaged groups" discussing the changes they feel necessary in the structure of the health care professions and their associations, so that their particular needs -- for both primary care and health promotion -- are met.
- . Screening of health promotion information and program materials for such biases as sexism, "middle-classism" and other components in the messages that do not represent the economic, cultural and social realities of disadvantaged groups.
- . That the emphasis on individual responsibility contained in health promotion messages will shift to the concept of social and collective responsibilities.

Group Recorder: Ron Labonte

RECOMMENDATION

The British Columbia College of Physicians and Surgeons change their policy regarding home-births, to allow physicians to attend home births without fear of losing hospital privileges, and to promote birth as a natural event in family health, as opposed to an institutional event which often creates trauma.

Revised wording:

Delete "hospital privileges", insert "licensure".

The recommendation presupposes the availability of data/information which supports it. Before any such action is taken (or rejected) the Ministry of Health should appoint an appropriate (i.e., representative and qualified) body to review the evidence on safety, effiacy, cost and acceptability of home births, and attempt to draw conclusions therefrom. This body should complete its report by the end of 1981.

In the interim the Ministry should immediately determine the situation in other provinces of Canada and inform the College to ensure that current practices in British Columbia correspond to that in the rest of Canada.

Group Recorder: Bob Evans

RECOMMENDATION

Since health lifestyles must be developed from birth, and since parents are the most influential agents in a child's life, that a multi-agency task force be established by December 1, 1980 to determine effective ways of involving parents in self-care and health promotion strategies for the family (particularly those parents who would not normally avail themselves of such programs). This task force will report its findings by December 1, 1981.

Action Plan

We recommend that the B.C. Ministry of Health consider developing as a priority effective ways of involving parents in self-care and health promotion strategies for the family (particularly those parents who would not normally avail themselves of such a program).

We recommend that this be accomplished through the establishment of a work group chaired by the B.C. Ministry of Health with a broad agency base of representation.

This work group will pursue four major tasks:

- a review of and identification of programs and materials which currently exist.
- identification of target groups - low income and lower middle income, single parent families and young parents.
- develop a mechanism for parental involvement and the determination of programs and materials which most appropriately meet their needs. This will imply a strong emphasis on self-care approaches.
- to look at ways of upgrading community health providers and their knowledge in the area of parenting, self-care and early childhood health.

The group will be called together by September 1980 and will report back by September 1981.

It is recommended that National Health and Welfare will cooperate with the B.C. Ministry of Health particularly in the areas of the review of programs and materials and network maintaining liason with contacts with other provinces who wish to undertake similar activities.

We recommend that other provinces consider establishing self-care and health promotion strategies for the family as a priority.

Group Recorder: Anne Ironsid

RECOMMENDATION

Our educational system should take leadership in modelling and teaching positive health practices to children. These practices should be an integral part of all school curricula, rather than taught in a fragmented manner.

Action Plan

We recommend that the B.C. Ministry of Health liase with the B.C. Ministry of Education to establish Health Education in the schools as a priority.

We recommend that there be a focus on three areas:

Teacher: we recommend that teachers be trained to teach health education.

Curriculum: that a core curriculum of health education for K-12 be developed.

Students: that the focus be on personal competence, self-esteem, self-confindence and decision making.

We recommend that teacher training commence in 1982-83 and full implementation be in place by 1985.

School environments should be more conducive to healthy lifestyles.

Group Recorder: Anne Ironside

RECOMMENDATION

Training programs for health professionals devote at least 25% of their curriculum to learning/teaching health promotion techniques by September 1981.

Revised Recommendation

Training programs for health care workers (from sub-technicians to M.D.'s specialists) include a major emphasis on learning/teaching health promotion techniques.

To Whom

Deans of Medicine, Pharmacy and Dentistry and the Directors of Schools of Nursing and Social Work at UBC and in hospitals where they currently exist (like VGH), Langara College and B.C.I.T. In addition, it should be directed towards licensing bodies for nursing, medicine, pharmacy and dentistry and to the Borad of Directors of health care institutions (such as hospitals) throughout the Province.

Group Recorder: Anne Ironside

RECOMMENDATION

Relevant professional associations should establish a joint task force to prepare and present a report by January 1981 to the citizens of British Columbia on the health status of citizens of British Columbia. The report should outline health improvement goals for the next twenty years. It should be based on input from relevant ministries, industries, agencies and citizens.

This recommendation was not dealt with by the Action Group, but is being pursued with the relevant agencies and will be reported on at the follow-up meeting of the Action Group.

APPENDIX

EVALUATION OF CONFERENCE
SUMMARY

The purpose of the evaluation was to determine the degree to which the conference fulfilled the purposes specified by its organizers and participants, and to obtain information to aid in policy development and in planning future conferences. This report is primarily based on data from questionnaires returned by 213 of the 320 conference participants. Responses were predominently health care providers, administrators or teachers, typically in government, hospital/clinic or university settings, and displayed a very positive attitude toward the "new" health promotion paradigm. The objectives most important to the participants dealt with applied professional development, with less interest expressed in discussing policy and cost/effectiveness. Overall, a moderate degree of success was achieved in fulfilling objectives. The practical, small group sessions and workshops were most highly valued, and a clear need was expressed for "more of the same". While participants were less enthusiastic about political and economic issues, many were grateful for a potential opportunity to influence policy. Overall, the respondents were highly appreciative of their experience at the conference, and indicated a strong sense of commitment to continuing involvement in the area of health promotion.

"a good beginning!"

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The full text of the evaluation is available at
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